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COMMUNICATIONS.

FOREIGN BODIES IN THE VAGINA.*

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Of Philadelphia.

The vagina has been more frequently the receptacle of foreign bodies, than has any other cavity of the human organism, and the variety of these bodies has been greater.

Among those which have been voluntarily or accidentally introduced by the female herself, may be mentioned † hair-pins, toilet-pins, needle-cases, crochet-needles, pebbles, spools, a pepper-box, a cotton veil, sponges, the bobbin of a spinning-wheel, the reel of a sewing-machine, lead-pencils, jelly-moulds, pewter cups, the neck and shoulders of a corked vial, the cup of a drinking flask, the socket of a brass candlestick, and the head and bust of a china doll. In regard to the last foreign body referred to, the history ‡ of the case was briefly as follows: A mulatto girl, thirteen years of age, in June introduced a doll's head and bust in the vagina, and in the succeeding November first complained of the suffering its presence caused; she assured her mother that she had swallowed the doll—her name was probably Sapphira—and it was only when partially anesthetized she confessed that she put it in her vagina;

*Read before the Philadelphia County Medical Society.

† Some in the list are taken from Briesky, "Die Krankheiten der Vagina," Billroth's "Handbuch der Frauenkrankheiten," while the authorities from which many of the others have been derived, will be mentioned in the course of the paper.

‡ Dr. Smith, New Orleans Medical and Surgical Journal, February, 1884.

both the truth and the baby came out under the influence of chloroform.

The motives which have led women or girls to voluntarily place foreign bodies in the vagina have been many, though not as numerous as the cases. A purse of money has been put in the vagina for concealment; a sponge has been placed at the mouth of the womb just before coition, in order to prevent conception, and forgotten until many months after, when deterioration of health, offensive discharge and hemorrhages from the vagina, and pain, led to the suspicion, if not the diagnosis, of cancer. In some cases the foreign body has been pushed, in thoughtless play, into the mouth of the vagina—sent on a sort of exploring tour, just as children drop pebbles into a well, or throw them in a cave; while in others, a morbid desire for sympathy, or to attract attention, may have been the motive for its introduction. In some cases the foreign body has been put in the vagina to stop the monthly flow; in two instances, girls menstruating for the first time—ignorant, surprised, and fearful at the discharge of blood—sought to arrest it by putting a spool in the vagina. In some cases the voluntary introduction of these bodies can only be attributed to an insane freak, or an arbitrary and unreasoning exercise of will, just as we have given in one of Juvenal's Satires, an example of a mistress who has her slave causelessly whipped, declaring, if my Latin be not at fault, *Voluntas sit pro ratione*.

In many instances, the foreign body has been introduced purposely, but has been accidentally retained. Thus a girl* has used a needle to

* Schmidt's Jahrbücher, 1870, p. 308.

make her menstruation freer, or a woman a hair-pin to procure abortion, and the instrument escaped from her grasp.

In some cases, the foreign body has been used for therapeutic purposes, and broken or become detached in the vagina. Thus a woman,* while taking a vaginal injection, loses the nozzle of her syringe; a troublesome leucorrhœa leads her after two months to consult a physician, and the lost body is found in the vagina. There are several cases reported where glass vaginal syringes have broken while in use, and the fragments remained in the vagina. In one of my patients, a married lady who had suffered from vaginismus, spontaneous fracture of one of Sims' glass dilators occurred when it was in the vagina, greatly to her surprise and alarm.

The foreign body may have been forced into the vagina by sitting down on it, or by a fall. A school-girl, on taking her seat, does not observe that a pencil is erect on it—the head below, the point above—and the pencil is thrust into the vagina, its point penetrating the bladder.

Jansen, of Ostend,† has reported the case of a woman who had an ale-glass, two inches and a half in diameter and three in height, in her vagina, which she asserted had entered from her sitting on it.

Trapenard‡ narrates the case of a woman sitting down on a faggot, being one of a pile; the faggot slipping, she falls some distance to the ground, and a triangular piece of glass and three spines of the acacia are forced into the vagina.

Salzer|| has narrated the case of a girl, thirteen years old, who, in a barn, slid down a pile of hay several feet high, and thrust into the vagina the iron part of a "heurupfer," which was lying concealed in the hay near the floor; the part of the instrument entering the vagina was nearly four inches long, and included the pointed end, and the projecting hook two inches in length.

But, according to Breisky,§ the most frequent accidental introduction of foreign bodies into the vagina has occurred in self-abuse—the body used escaping from the hand, and the party being unable to reach or to remove it.

The foreign body may be formed in the vagina. It is not uncommon to find in a patient who has suffered for some time from a large vesico-vaginal

fistula, calculous concretions on the vaginal wall in the vicinity of the abnormal opening.

The foreign body may have come from an adjacent cavity. In case of recto-vaginal fistula, or where there is complete rupture of the perineum, feces may be in the vagina. So, too, this accident has occurred even when the rupture of the perineum is only partial, as in the case of a young physician's wife, detailed by Breisky.*

Intestinal parasites may pass directly through a recto-vaginal fistula, or over the perineum, into the vagina. Thus there have been found in the latter oxyures, and the *ascaris lumbricoides*; but these are estrays, not true parasites of the female sexual organs.

Hausmann, in his work upon "Parasites of the Female Sexual Organs," states that in two instances he has found not only the *ascaris lumbricoides* in the vagina, but also the eggs; moreover, he has found in the vagina the eggs of the *tænia solium*. He mentions, too, a very curious fact, finding the itch insect in the vagina of a woman who had no external evidence of the presence of this parasite, the skin entirely free from disease, and he regards it as not at all improbable that under such circumstances the acarus was introduced in coition, for, according to Kuchenmeister, the acarus is in many cases abundantly reproduced upon the penis.

It may happen that a uterine fibroid undergoes calcareous degeneration, and some of the calcareous fragments, or the entire tumor, enter the vagina. Dr. Goodell† has given an illustration of the former, while Gaubius‡ has furnished one of the latter occurrence. The patient of Gaubius was a virgin who had a uterine calculus so large that after it entered the vagina he could not remove it until he incised the vaginal mouth.

The greatest number of vaginal foreign bodies are tents, tampons, and pessaries—introduced for therapeutic purposes and left, through carelessness, or by accident, after these therapeutic purposes have been accomplished.

Uterine tents expelled from the uterus have remained injuriously in the vagina. Elliot|| has reported the case of a woman who, thirteen months after labor, suffered severe pain in the pelvis, and had such an offensive vaginal discharge that she thought she had "mortification of the womb." Upon examination, a tampon

* *Le Med. Practicien*, January, 1882.

† *Lancet*, vol. II., 1850.

‡ *Archives de Tocologie*, 1881.

§ *Berliner Klinische Wochenschrift*, 1875.

|| *Op. cit.*

* *Op. cit.*

† *American Journal of Obstetrics*, May, 1883.

‡ *Journal de Medicine*, par Vandermonde, 1759.

§ *Boston Medical Journal*, 1837.

was found in the vagina, which had been placed there just after her labor to stop hemorrhage.

The number of cases in which pessaries have remained an injurious time in the vagina is very great, and hardly a practitioner of five years' experience, who has not removed these foreign bodies. The late Dr. Atlee was accustomed to say in medical meetings, when the subject of pessaries was under discussion, that he had removed more pessaries than he had ever introduced; plainly it was impossible for him to accept Dr. Hodge's views of uterine pathology and therapeutics, as it was, for a time at least, for Dr. Hodge to accept Dr. Atlee's opinions and practice in the treatment of ovarian tumors. But apart from exclusive views, very many pessaries, unsuitable in form or size, or unnecessarily applied, or worn for too long a time, need to be removed. In reading some of the histories of removal of such foreign bodies, one is often struck with the great length of time which they have been worn before their injurious effects compelled seeking professional advice.

Sutton* removed a glass ball pessary that had been in the vagina fifteen years; Desormeaux and Dubois† mention a case where a silver-gilt pessary had remained for twenty-five years; Goodell removed a glass disk after thirty years' imprisonment; and Sabatier‡ had a patient who had worn her pessary forty years.

It does seem extraordinary that the vagina ever tolerates these foreign bodies so long a time, and yet a case reported by Pearse|| is almost as remarkable; his patient had had a cotton veil in the vagina for twenty years. So, too, the case reported by Hauff is very remarkable. A nullip.,§ twenty years of age, had introduced into her vagina a coffee-cup, eighteen centimetres in circumference, and three and a half centimetres in diameter; it was removed entire after having been worn two years and a half.

So far, reference has been made to foreign bodies that have been introduced into the vagina by the patient herself, or by accident, or by the physician for therapeutic purposes. Foreign bodies have been put in the vagina, by men, from thoughtless or designed cruelty. A country girl had worn for years, before coming under the care of Dupuytren¶, a pomade-pot in the vagina; some

brutal soldiers, after making her the unwilling victim of their lust, had thrust in this foreign body.

Among other of these abominable cruelties may be mentioned the introduction of the cone of a fir tree,* a turnip,† a large crystal of sulphate of copper,‡ a wine-glass, etc. Günsberg|| gives the case of an idiotic woman whose husband forced into her vagina a wine-glass, the stem of which was broken off; twenty-four hours after the cruelty was inflicted the wine-glass was removed, not without some laceration of the vagina, a forceps and Sims' speculum being used in the removal.

Instead of one foreign body there may be two or more. Schroeder§ mentions a case under his care in which there were a cockchafer and a pomade-pot in the vagina; in Trapenard's case, previously stated, there were four foreign bodies; other illustrations are furnished by the fragments of a broken syringe, by some cases of vaginal calculi formed in consequence of a vesico-vaginal fistula, and by oxyures. But the largest number of foreign bodies is given in those instances where a needle-case has been introduced closed, and when in the vagina is opened, the needles then escaping; Grenier¶ has given two cases in which this occurred.

An interesting case has been given by Dr. Graham,** where there was not only a foreign body in the vagina, but there was also one in the bladder—a spool in the former and a hair-pin in the latter; the spool had been in the vagina three years, and it was supposed that the hair-pin, which was bent in the form of a crook, had accidentally entered the urethra when the patient was attempting to remove the spool.

In considering the consequences of foreign bodies in the vagina, the least frequent will be referred to first.

There may be a serious wound of the vagina immediately resulting from the foreign body. In several of the cases where glass syringes have broken in the vagina, the latter has been wounded. Dr. Oldham†† has narrated a case in which death followed such wound; the death occurred the twelfth day, from internal hemorrhage.

* Supplement to the American Journal of Obstetrics, January, 1882.

† Dictionnaire de Medecine.

‡ Medecine Operatoire, Paris, 1882.

§ British Medical Journal, vol. i., 1878.

|| Centralblatt für Gynæcologie, 1879.

¶ Bibliothèque du Médecin-Praticien.

* Breisky, op. cit.

† Breisky, op. cit.

‡ Medical Times and Gazette, 1863.

|| Centralblatt für Chirurgie.

§ Diseases of Women.

¶ Theses de Paris, 1834.

** Nashville Journal, 1858.

†† Lancet, vol. i., 1870.]

The foreign body may enter adjacent organs, or penetrate into neighboring tissues, partially or completely passing out of the vaginal canal. In a patient under the care of Dupuytren,* an ivory pessary, which she had worn for many years, had partly entered the bladder; and partly the rectum, so that it occupied not only the vagina, but the other cavities mentioned. The same condition was present in the case of Desormeaux and Dubois.†

In the case of the girl 15 years old, who had the vagina entered by a lead-pencil, the point penetrating the bladder, there was a calcareous deposit upon the part within the bladder. The removal, which was done six months after the injury was received, could not be accomplished until after an incision of the vesico vaginal wall was made.

Those cases in which the foreign body passes into the uterus, partially or completely, are most remarkable. The late Dr. Crowe, of Louisville, Ky., reported a case in which a Babcock's pessary had in part entered the womb; in the *New Orleans Medical and Surgical Journal*, 1883, a case is given in which the socket of a brass candle-stick, three inches and one-fifth in length, four-fifths of an inch in diameter, and having a rim an inch and a half in diameter, was found in the uterus; this foreign body had first been introduced into the vagina.

Dr. Lever‡ reported the following case: A woman while applying some ointment by means of a bone netting-needle, to allay irritation of the vagina, is disturbed by some one unexpectedly entering the room, and sits down suddenly; the instrument is forced into the vagina, and through the vaginal wall; in her efforts to remove it, it passes entirely out of the vagina and lies in an oblique direction to the right side of the latter. Nearly seven months after its introduction, this foreign body, which was six inches long, was removed, the removal being preceded by dividing it.

The foreign body remaining in the vagina may be encrusted by a mineral deposit. This deposit is composed of the triple phosphate and calcium salts. One of the most interesting specimens of such incrustation was presented, a few years ago, to the Philadelphia Pathological Society, by Dr. Getchell.¶ This calculus had been removed from the vagina of a girl nineteen years of age:

it was three inches long, one inch and a quarter wide, three-eighths of an inch in thickness, and had been formed about a hair-pin as a nucleus. In the discussion following the presentation of the report and the specimen, the view taken by those Fellows who discussed the origin of such formations, was that they were usually derived from urinary salts. Such origin may be admitted as probable, though by no means proved, if there be a genito-urinary fistula; but if there be no such abnormal communication, how can urine enter the vagina, especially its upper part, where the foreign body is most frequently found? Breisky, in describing the effects of these foreign bodies in producing irritation, etc., of the vagina, states that the deposit comes from the stagnant secretions in the vagina, and he compares the foreign body thus incrusted to a foreign body in the bladder which serves as the nucleus for a vesical calculus.

A remarkable case of vaginal, uterine, and vesical calculus under the care of Prescott Hewett* occurred some years ago at St. George's Hospital. The patient had introduced into her vagina, eleven years before, the neck and shoulders of a large corked vial. The portion of the vial was covered with calcareous matter, and was in the vagina; the os uteri was blocked up with a mass which proved to be the cork similarly incrusted, and there was a calculus in the bladder; this patient had a small urinary fistula at the fundus of the bladder.

In some of the cases where perforation of the vesico-vaginal wall has occurred, the tissues gradually worn away by the foreign body, it has not been mentioned that any urine escaped from the vagina, and yet the portion of the foreign body remaining in the latter was covered with abundant incrustations; in one of these cases where the rectum and the bladder had each been entered by a part of the foreign body, so perfectly were the openings plugged by the body, it is expressly stated there was neither a urinary nor stercoral fistula.

Another consequence of the presence of a vaginal foreign body observed in some cases, is the production of abundant granulations from that part of the vaginal wall with which the body is in contact, so that after a time the latter is more or less completely imbedded, hidden from sight and touch, it may be. There may be associated with this a very marked stenosis of the vagina, the lower portion being of full size, while a small aperture leads to the upper part which contains the foreign body.

* Bibliothèque du Médecin-Praticien.

† Op cit.

‡ Medico-Chirurgical Transactions, volume xxxi.

¶ Philadelphia Medical Times, 1873.

* Medical Times and Gazette, 1854.

In the case where a large piece of sulphate of copper was passed into the vagina, sloughing of the entire vaginal mucous membrane resulted. The victim was a girl seventeen years old, and the perpetrator of the crime, a young man, who introduced the foreign body after having had intercourse with the girl. A few hours after its introduction it was removed, and then weighed six drachms and a half.

In general the effects produced by these foreign bodies depend upon their form, size, material, the greater or less violence done in their introduction, and the length of time they remain.

They usually produce more or less irritation of the vaginal mucous membrane, with increased secretion. In many cases an obstinate leucorrhœa, compelling the patient to seek professional advice, leads to the discovery of the foreign body. The increased vaginal discharge is at first mucous, then muco-purulent, or purulent, or it may be serous, but after a time becomes more or less offensive in odor—in some cases so offensive as to suggest malignant disease, a suspicion which may be confirmed by the occasional or frequent occurrence of hemorrhages. The foreign body may interfere with the functions of neighboring organs, especially those of the bladder and rectum; hence vesical irritability or dysuria, or rectal tenesmus, in some cases dysentery.

The vaginal surface may be abraded, or ulceration of the walls occur from pressure of the foreign body; adding to these the offensive character of the retained vaginal secretions, we have the conditions which may lead to septic infection. Kottman* has reported a death from this cause in a woman twenty-five years old, who introduced a spool into the vagina, and who had suffered from leucorrhœa several years. The spool was found behind the cervix in the vaginal vault, and removed; symptoms of peritonitis were well marked, and the patient died; the post-mortem showed purulent exudation in the pelvic peritoneum, especially in the recto-uterine cul-de-sac at a point corresponding with that which the spool had occupied in the vagina.

Runnals† has reported a case of death from pyæmic pneumonia and peritonitis, occurring in a girl of twenty-four years, caused by the retention of a piece of sponge in the vagina; the measurements of the sponge, removed after death, were three and a half by two inches.

A girl,‡ eighteen years of age, was admitted

into Hotel Dieu, Orleans, apparently in the last stages of marasmus, and complaining of hypogastric pain, and diarrhœa. The next day she died, and upon post-mortem examination, there was found in the vagina a pewter cup, which had been introduced fourteen months before; it is stated that the cup could not be removed before dividing the pubic joint.

Dr. Kelly,* of Philadelphia, was consulted by a woman seventy-five years old, who had worn a pessary fourteen years without inconvenience, until recently difficulty in defecation and urination, together with an offensive vaginal discharge, led her to seek professional help. The doctor, not without considerable difficulty, removed the pessary, but the woman soon manifested a typhoid condition, and died three weeks after the removal.

The presence of a foreign body having been determined by vaginal examination, by touch, mediate or immediate, by sight, where possible, and the vaginal examination assisted, if necessary, by examination through the bladder and the rectum, the plain indication is to remove the foreign body.

Here one cannot refrain from stating the very great advantages the practitioners of to-day have given them by Sims' speculum and anæsthetics in such removal.

An anæsthetic is not necessary in all cases, but is especially in children, and when the foreign body is large.

So far as methods of removal are concerned, these vary with the size and form of the body, and its material, and as to its being free or fixed in the vagina. In many instances the conditions require a new method to be devised.

In some instances the foreign body can be best removed by acting on it through the rectum. Thus Meissner removed a pebble from the vagina of a girl 2½ years old; of course very much less violence was done by the finger in the rectum, than if it had been introduced into the vagina. Small round bodies can be best removed by throwing into the vagina a stream of water, while the perineum is retracted by Sims' speculum. The removal of fragments of glass, especially of a syringe, is often difficult; if forceps be used, there is danger of breaking the glass, or of wounding the vagina; in the only two cases I have had to remove the pieces of a broken glass syringe, this was done by the fingers, and, in general, flat bodies are thus best removed.

One of the most ingenious devices for the removal of fragments of glass was used many years

*Schmidt's Jahrbücher, 1875.

†British Medical Journal, July, 1882.

‡Lancet, vol. 1, 1848.

*Medical News, Philadelphia, 1884.

ago by Dr. Levis. A woman had a broken glass pessary in the vagina, and the efforts that had been made to remove the pieces had only resulted in reducing them to smaller pieces, comminuting them in fact; a severe vaginitis—due chiefly to the fragments of glass, but in part, probably, to the attempts at extraction—was present when the patient came under the care of Dr. Levis. He threw into the vagina by means of a syringe a mixture of plaster of Paris, and after two or three days removed the mass, the solidified mixture having fixed in it the various pieces of glass. This unifying process, so ingeniously resorted to by Dr. Levis, seems like a material illustration of Plato's axiom that the end of philosophy is the intuition of unity.

In some cases it has been necessary to reduce the size of the foreign body before extracting it. Thus Dupuytren broke the pomade-pot, and, by means of strong forceps devised for the purpose, divided the ivory pessary in the vagina and in the rectum, removing one part through the latter, the other through the former. In other cases the vaginal orifice has been enlarged by incision, as was done by Gaubius for the removal of the calcified uterine fibroid, and by Sutton for the removal of a globe pessary. If granulations have fixed the foreign body, these must be detached by the finger, or divided by scissors.

If the foreign body have its size greatly increased by mineral incrustations, it is advised to remove these first. Another reason for their removal lies in the fact that in some cases the rough, jagged surface may injure the vagina when extraction is done. Sabatier speaks of his fingers being wounded by the "asperities of saline incrustations," which had made the tumor "as rough as a rasp."

In some cases the ordinary polypus forceps is an excellent instrument for removal of a foreign body, but this removal should then be made by sight rather than touch—a Simon or a Sims speculum being used to expose the vaginal cavity.

In others the foreign body has been so large that the obstetric forceps has proved necessary for its removal. Roux, probably, was the first to use the instrument for this purpose, though some since his day have suggested its utility, imagining they were proposing something new; this is like many other novelties in the medical world which are exhumed from the grave of years, or even of centuries.

Whatever means, manual or instrumental, are used for the removal of foreign bodies from the vagina, it is well to be guided by the words which

Blundell said could be usefully inscribed on one of the blades of the obstetric forceps: *Arte, non vi.*

In all cases where there is an offensive vaginal discharge, or any erosion or ulceration of the vaginal walls, antiseptic injections should precede, and for some time follow, the removal of the foreign body.

THE ROLE OF BACTERIA IN PARTURITION.*

BY HENRY O. MARCY, A. M., M. D.,

Of Boston.

Under this title Dr. Marcy read a carefully-prepared paper upon the processes of parturition and the dangers incident to septic exposure.

He premised by a review of the processes of reproduction, embodying the results of his own investigations, undertaken to verify the teachings of the great Italian master, Erocoloni. The uterine glands elaborate the so-called catamenial decidua. Of the same glandular product is the decidua of pregnancy—*D. Vera*. This glandular secretion serves for the nutrition of the fetus during the early period of pregnancy; later the nutritive fluid is elaborated by the complex glandular organ known to us as placenta. The Serotinal or secretory cells of this organ are themselves elaborated from the sub-mucous layer of uterine connective tissue, and when these are separated, as a more or less perfectly formed placenta, there takes place an extensive traumatic lesion of the uterus, laying bare the uterine tissue of the entire placental site.

Uterine contraction rapidly reduces the extent of this traumatic lesion *pari passu* with the size of the organ, and this process also hastens the proliferation and expulsion of the broken-down, used-up material.

This must be *physiologically* an aseptic process.

The *pathological* factor must lie in abnormal and extraneous conditions.

The most common and important is the hitherto *x* factor in the problem, now, at least in part, recognized as bacterial ferment. Whence its origin? Certainly from without. If excluded from foreign contact or atmospheric exposure, the uterus in its injuries, even in the cervical portion, may be likened to a subcutaneous wound. Then the lochial secretion remains a non-irritant, innocuous fluid, although a highly albuminous fluid swimming with broken-down cellular debris.

Micro-organisms are usually found in the vagina in health. Would this furnish the seed

*Read before the American Medical Association, April, 1885.—Abstract.

for septic infection? Were this true, why does not every woman have after labor a septicæmia? The belief that herein lies danger is widespread, as evinced by the earnest advocacy of a large number of our most experienced and thoughtful practitioners of the vaginal douche in normal labor.

This belief is greatly strengthened by the common observation, that the napkin used for the absorption of the lochia has a decided unpleasant odor; and if the secretion be examined microscopically it will be found teeming with bacteria-termo, the omnipresent scavenger of nature for taking to pieces and perhaps refitting for higher uses our waste albuminous compounds. It is possible by this very process that this material is diverted from falling into the hands of and feeding an army of most dangerous enemies. This, in the mind of the writer, was the explanation why, amid filthy surroundings, the unwashed, unchanged, uncared-for women so very generally make a good recovery.

Dr. Marcy emphasized cleanliness as important for the same general reasons imperative in wound treatment; but because of the physiological conditions and relations, as above sketched, he discards as unnecessary the vaginal douche in normal labor. He quoted from an exhaustive paper by Dr. Z. B. Adams, of Framingham, Mass., many facts showing that the douche thus used, even in competent hands, might be a source of danger, even death. Prof. Schroeder, of Berlin, has recently had two fatal cases where the mercuric bichl. sol. 1 to 1000 was used.

In all operative cases, however, where septic infection might supervene therefrom, Dr. Marcy would insist upon the most rigorous exercise of antiseptic precautions as the fundamental factor of preventing infection. This had been advocated in the Boston Gynecological Society by the writer six years ago—a surgically-clean operator, clean instruments, etc.

The same general conditions pertain to the problem as belong to operative wounds. It is, however, emphasized and rendered much more important than in ordinary wounds, when the general conditions are thoughtfully considered. In both cases there must exist not only the *seed* as the danger material, but also the *soil*. The planting ground is rarely the vagina, but the uterine cavity. It is difficult to conceive of an incubating chamber presenting more favorable conditions, the albuminous fluid furnishing abundance of food, the heat-point steadily maintained; open sinuses, lacerated vessels, denuded walls,

through which ramify an abundant network of lymphatic vessels, all furnish conditions for generation and absorption rarely equaled. Micro-organisms thus rapidly generated are distributed with astonishing facility, and a general infection rapidly supervenes.

Dr. Marcy followed with a series of interesting experiments to show that the danger resulted, as a rule, from micrococcal and not bacillary poisoning. This was deemed the more important, since here the odor was not marked, only slightly sour, and therefore that which has usually been considered an important characteristic is wanting. Viewed from this standpoint, the subject of puerperal fever assumes a new and more intense interest. No subject in preventative medicine is of greater importance, and there can be no doubt that lives in large numbers have been saved by the adoption of wise precautionary measures, based upon the knowledge already attained of the role of micro-organisms in puerperal lesions.

Dr. Marcy closed by insisting that the subject, instead of being exhausted, was opening up new fields for better study and richer fruitage. Hecatombs of lives, of women in the ripe maturity of their usefulness, should no longer be annually sacrificed through the ignorant violation of laws now demonstrated.

HOSPITAL REPORTS.

CLINICAL LECTURE ON CARDIAC DISEASE IN ADOLESCENCE—ACUTE AND CHRONIC PERICARDITIS—HYDRO-PERICARDIUM.

BY JOHN M. KEATING, M. D.,

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Reported by WILLIAM A. EDWARDS, M. D.,

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Before proceeding directly to the cases before us, it is perhaps as well to brighten up our knowledge of the pericardium and its topographical anatomy.

The heart, the origin of the large vessels, and the serous pericardium, are contained within and enclosed by the fibrous sac of the pericardium. The pericardium is situated in the median line of the thorax between the two lungs and the pleuræ; posteriorly it is in relation with the posterior mediastinum, separated from the spine by the connective tissue inclosing the trachea, descending aorta, great vena azygos, intercostal arteries and veins, thoracic duct, œsophagus, two pneumogastri-
cals, and both sympathetic nerves and lymphatic glands.

Anteriorly, the pericardium is separated from the sternum by connective tissue and the anterior border of the pleuræ.

The sac of the pericardium is shaped like a triangle; the apex of this pericardial sac is fixed to the skeleton by three important ligaments. It is fixed to the vertebral column by the suspensory ligament of the pericardium, sometimes unfortunately called Beraud's* ligament, as by giving men's names to anatomical structures we simply complicate matters. It is inserted into the middle and left lateral portions of the third cervical vertebra.

The second ligament of fixation is the cervico-pericardial pseudo-aponeurosis of Richet; this coalesces with the middle aponeurosis of the neck, and is inserted into the hyoid bone.

The third support has been described under two heads, as the sterno-pericardial and the costo-pericardial ligament.

It is also upon these ligaments that the great vessels going to and arising from the heart are supported. The base of the pericardium is fixed to the centre of the diaphragm. Those of you who desire more extended data on the anatomical points I would refer to the work of Constantin Paul.

The pericardium has two layers, parietal and visceral; the latter is thin and separated from heart-muscle by connective tissue; it is here that you often see excessive quantities of fat deposited. The serous cavity contains a variable amount of fluid, which is alkaline, and made up of water, albumen, fibrin, salts, solid parts, and extractives.

Let us now now examine our case. Willie O., æt. 14, first complained of a sharp, severe præcordial pain below the nipple, and radiating towards the ensiform cartilage; this was its maximum intensity. It was quite painful throughout the entire præcordial region, and even in the epigastric and left hypochondriac regions. He tells us that coughing made it worse, as did also the respiratory act; he describes the pain as lancinating or tearing, and almost unbearable. The causes of this acute pericarditis are many. It is seen with endocarditis and rheumatism; after scarlatina, as an extension from the pleura; it may arise as a sequel of acute Bright's disease. A septic form of endocarditis, and also, possibly, of pericarditis, may have its origin in the new-born babe from an umbilical sore. Occasionally it is seen in typhoid fever, variola, and erysipelas.

Steiner makes the observation that the usual rule in practice is to consider all cases of heart disease that occur before the age of four years to be congenital; but Goodhart† takes exception to this statement, as sixteen of his cases occurred under four years of age, and Cox records a case of pericarditis in an infant eleven days old.‡

Acute pericarditis is seen more frequently in children than in adults, in association with infective osteo-myelitis and abscess in the heart.

The symptoms of pericarditis may be very obscure; in some cases but few symptoms are presented, the child loses flesh, becomes breathless, palpitation is noted, and a short dry cough would complete the symptoms of one of these obscure cases. When the pericarditis is accompanied by a serous effusion in one of these young emaciated

subjects, the enlargement of the pericardium can sometimes be easily detected simply by inspection. Graves has noted in infants the pushing out of position of the left lung, its apex extending into supra-clavicular fossa.

There are certain general diagnostic symptoms that you must learn to note. The temperature is apt to be high, but undergoes decided fluctuations; dyspnoea may be extreme and threatening, the nares dilate, sometimes as markedly as they do in pleural effusions. Hiccough is frequently noted, the face is pale and expression anxious. Your patient may be in a state of delirium or of extreme wakefulness.

If you lay your hand on the præcordia in the early stage of this affection, when the fibrinous exudate is undergoing formation, a rough friction may be felt. It is well when seeking this sign to ask your patient to lean forward. The friction of course disappears as soon as the effusion occurs, as the two surfaces of the inflamed pericardium are then removed one from the other.

Percussion is a most important aid; much more so in children than in adults; a difference in the percussion note may be elicited by changing the position of your patient; this, however, is a difficult feat in physical diagnosis when dealing with young and often ungovernable children.

Auscultation enables you to "clinch" the diagnosis; the pericardial friction sound is absolutely diagnostic; the only thing that you may mistake it for is a pleural friction; this point is easily definitely settled by asking your patient to refrain from breathing; the pericardial murmur will now be seen to be synchronous with the cardiac rhythm, and the supposed friction rate to have disappeared.

You can increase a pericardial murmur by pressure; it is also very superficial, and is not propagated, as you know valvular murmurs are. You will generally find these friction murmurs to have their greatest intensity at the left border of the sternum, in the third or fourth intercostal space. The time of the murmur is systolic; that is, when the two inflamed surfaces rub against each other, it is sometimes heard in diastole when these surfaces leave each other. Some observers time the murmur as just before the first or systolic cardiac sound. The sound is generally rough. Collier compares it to new leather; it has been described as scraping or rasping, rubbing or rustling. Another point worth bearing in mind is that the murmur is greatly acted upon by active therapeutic measures; cups, leeches, or counter-irritants almost wholly alter its character; it is also modified by position, and it is more likely to be rough than soft.

Acute pericarditis may entirely recover, or it may become chronic. The condition of affairs that Stokes called pericarditis obliterans and Bouillard ankylosis of the heart, we generally now term one of pericardial adhesions.

These adhesions take various forms; bands are sometimes formed, which may break and result in long filaments attached at one end to the pericardium; at other times partial adhesions may be scattered here and there, or you may see the adhesions general. The adhesions may be firm, tense, and hard, or thin and easily removed; they may be so extensive as to obliterate the sac of the

* Gazette Médicale, 1862, p. 162.

† Diseases of Children, 1885, p. 527.

‡ Bull. N. Y. Path. Soc., 1881, p. 8

pericardium, the visceral and parietal layers being, as it were, glued together.

In later life these adhesions may undergo various degenerations—calcareous, tubercular, or cancerous.

Betrier* observed these extensive adhesions as early as eleven months.

The symptoms of pericardial adhesions are more or less obscure, and often overlooked. This lad, aged fifteen and a half, in whom we suspect the presence of this condition, gives us a history of antecedent acute pericarditis; and, indeed, this is a valuable aid in diagnosis; in many cases the question of the existence of adhesions remains hypothetical. Systolic retraction of the intercostal spaces merits a certain amount of attention.

An observer is of the opinion that if cardiac hypertrophy is present, with a violent impulse of the heart as a whole, but a feeble impulse of the apex, we are justified in suspecting pericardial adhesions.

Chronic pericarditis is, as a rule, a sequel of acute, or of rheumatism; it is not very frequent in children.

Hydro-pericardium is an infrequent disease in childhood. It is a concomitant of dropsy, or anasarca; the sub-serous tissue becomes oedematous, and an effusion is poured out into the sac. No trace of inflammation is to be noted upon the pericardium. It is due to a local or general condition; locally stasis in the veins or lymphatics of the heart or surrounding parts could cause it. Other cases may have as their etiology, nephritis generally parenchymatous, dropsy, tuberculosis, or more rarely cancer.

The affection generally sets in as the last act in one of the above grave diseases, and the diagnosis under these circumstances is difficult in the extreme. Such a case would probably present a small, weak pulse, cyanosis, decreased urinary secretion, compression of lungs, and pushing down of the diaphragm, with increased præcordial dullness and muffling of the heart sounds.

Solicitous parents will always desire to know your prognosis, and remember that acute peri- and endocarditis are more liable in children than in adults to lead to a rapidly fatal termination. In children rapid dilatation of the cardiac cavities may suddenly occur, and the child succumb to cardiac arrest. Remember also the younger the child the more rapidly will emaciation occur, hence your prognosis should be guarded, more especially should you discover consolidation of the lungs, great rapidity, or turbulent heart action. Vomiting would be a prognostic sign of evil omen; inability to lie down or take food, together with insomnia, should put you on your guard.

In the treatment of acute pericarditis, the first indication is the relief of pain. Opium is borne well in cases of children between the ages of six and fourteen. Absolute rest in the least distressing position, the head not very high, the senses not disturbed, no light, noise, or conversation, are all essentials in the treatment. This absolute rest is the more important, as the heart may have deposited on it a large layer of lymph, its muscles degenerating and its cavities dilating.

You should restrict the patient to a liquid diet, such a diet as will place the least possible strain upon the heart.

Counter-irritation by a blister is perhaps the best method of treatment. The blister should be large and allowed to draw well.

Dr. Beale suggests the following application after the blister has risen:

R. Pulv. opii,	ʒj.
Ungt. hydrarg.,	ʒj.
M. Ft. ungt.	

An ice-bag may be applied in cases of high temperature with tumultuous heart action and frequent pulse. You must watch its action so as not to depress the patient. Belladonna, bromide, and iodide of potassium may be given to fulfill their well-known indications.

A child of say ten years may take three to four ounces of wine per day as indicated. The great frequency of the pulse and the condition of the nerves of the heart can be met with digitalis.

R. Tr. digitalis,	ʒxx-xl.
Pot. bromid.,	gr. xl.
Mucil. acacie,	
Syrupi aurant.,	āā f. ʒij.
Aque, q. s., ad.,	f. ʒiv.

M. S.—Tablespoonful three times a day for child 6 to 12 years of age.

Of course, should rheumatism be at the root of the trouble, you must actively treat it. Sodium salicylate could be given cautiously and in small doses, watching its action intelligently.

Day suggests the following in rheumatism:

R. Pot. bicarb.,	ʒij.
Pot. nitrat.,	gr. xv.
Tr. opii,	ʒxvj.
Syr. limonin,	f. ʒss.
Aque, q. s. ad.,	f. ʒiv.

M. Dessertspoonful every three hours for a child six years old.

The treatment of serous pericarditis, or pericardial effusion, brings up the question of paracentesis pericardii; serous effusions in children possibly have a tendency to form pus more readily than in adults, so bear this in mind in a prolonged case of pericardial effusion, more particularly should your patient be sick, pale, and anæmic. In a case like this, I should consider it good practice to explore the pericardial sac by a fine hypodermic needle; if pus should be found, you, of course, must establish free drainage. I would impress upon you the great importance of keeping a hypodermic syringe and needle solely for exploratory puncture, as in many cases it is almost impossible to settle the question of the presence or absence of fluid without this puncture.

Diuretics and hydragogue cathartics have been tried in cases of pericardial effusions without, I think, doing very much good. The most useful ones of the former class are squills, nitrate and acetate of potash, and of the latter, jalap, scammony, colocynth, and elaterium.

The treatment of pericardial adhesions consists in the application of blisters and the administration of saline aperients, iodide of potash, and anti-rheumatic remedies.

During convalescence, see to it that your patient has absolute rest and avoids all bodily exer-

*Constantin Paul, Diseases of Heart.

tion; a child should not be allowed to place its feet on the ground at all, but the nurse should be directed to carry the little patient. You must frequently note the pulse rate and heart's action, order an easily-assimilated diet, direct the proper hours of rest and sleep so that the heart may rest as the body does during sleep. Iron is now indicated to restore nutrition of heart and enable it to repair any damages.

MEDICAL SOCIETIES.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

(Continued from page 13.)

Gestation in a Sarcomatous Uterus Simulating Extra-Uterine Pregnancy.

By Dr. Bernardy.

October 3, 1884, I was requested to visit Mrs. McG., delicate, aged about thirty, married six months. She was said to be suffering from a cold. I found the patient up. Temperature 105°, pulse 130, with a high fever and a severe cough. Examination of the lungs revealed double pneumonia. At the same time noticing the abdomen prominent, I inquired and was informed that pregnancy was five months advanced. The abdomen was rather large for that period. On Sunday, October 5, she complained of a sharp pain in the right inguinal region, the pain was excruciating and demanded the administration of large doses of morphia before any relief was obtained. I found the right inguinal region filled by an immense growth reaching almost to the lower border of the liver. The uterus, or what appeared to be the uterus, was enlarged and pushed well toward the left side. On vaginal examination, found the right side of the pelvis filled by a growth. At first thought I detected fluctuation, but closer examination showed it to be hard to the touch. The uterus was jammed well toward the left, and was immovable, the neck somewhat absorbed, the os tilted up behind the pubis. To reach it, the finger had to be passed well upward; it was closed and soft. The patient had never had any uterine trouble, menses always came without pain; they never appeared after her marriage, which occurred one week after a period. Her health remained good for three months after marriage, when, while out walking, she was suddenly seized with a sharp, lancinating pain in the right side of the abdomen. The pain was so great that she almost fainted, but being a woman of strong will, she finally, after suffering terrible agony, reached home, and went to bed. No physician was called in; next day there were slight traces of blood on her night-dress. Under absolute rest, the pain subsided, and at the end of a week she was about her household duties. The pain in the side returned if she over-exerted herself. Sexual intercourse was painful, and was followed by traces of blood the next day. Believing that the symptoms pointed to either extra-uterine pregnancy or a tumor complicating pregnancy, I asked Dr. Goodell to meet me. By the time the consultation was held (October 8), a severe attack of peritonitis had commenced. This complicated matters, as a close examination was impossible. On account

of the distended and painful condition of the abdomen it was impossible to trace any outline of the growth or uterus. It was decided that the symptoms and history pointed to extra-uterine pregnancy, but that undoubtedly the uterus contained something, whether tumor or child, in the present condition of the patient, it was impossible to decide; the leaning was toward a pregnant uterus. By October 16 the peritonitis was under control; the lungs no better.

October 19 I was sent for, the messenger stating that there was a renewal of the peritonitis. I found the patient in active labor, the fetus descending rapidly. In half an hour labor was completed. I readily detected the large growth filling the upper portion of the right side of the pelvis. The uterus was surrounded by a hard growth. The cervix was hard. From this time the lungs improved, but she remained extremely weak, and there was a constant dribbling of blood from the vagina.

November 3, the growth was still present, and the cervix hard, and I began to think of malignant disease in connection with the tumor. I had applied, night and morning, to the abdomen. ungt. hydrg., bellad. and iodine, equal parts. This seemingly had the effect of causing the absorption of the large growth, but the mass surrounding the uterus remained the same.

November 27, vomiting occurred, and was arrested with difficulty. A bloody discharge from the vagina and a constant sore feeling over the region of the uterus, which was still towards the left side. The patient's condition was good; she was extremely weak; the slightest exertion would exhaust her and bring on bleeding from the uterus.

December 26, I found her suffering from pleurisy, the left pleural cavity full of fluid.

January 1, abdominal dropsy had set in. A consultation with Dr. Goodell was held. A positive diagnosis of malignant disease was made.

Prognosis.—Death at any moment. She died suddenly the same evening, while talking to her husband.

Post mortem examination by Dr. E. A. Russell twenty-four hours after death. Patient greatly emaciated.

Thorax.—A large amount of effusion completely filling up the left pleural cavity, while the cavity of the right side was partially filled; both lungs were compressed upwards, no adhesions. On section the lungs appeared mottled, and were hepatized in general appearance, but were otherwise healthy.

Heart.—On opening the pericardium, found a moderate amount of serous fluid vegetations on mitral valve, weight 11 ounces.

Abdomen.—Entire cavity was greatly distended with a dark fluid, full of broken down lymph. The intestines were forced upwards. There were slight evidences of beginning peritonitis. A portion of the ileum on the right side presented a black, unhealthy appearance, bordering on gangrene. The uterus was increased in size. The outer surface presented an irregular, mottled appearance; large veins covered its surface; at the fundus there appeared a spot about one inch in diameter, of a bluish tinge. On pressure by the finger, the surface readily broke. Underneath

was a cavity about the size of a large hickory-nut. It did not communicate with the interior of the uterus. On opening the uterus its cavity was found to be almost obliterated; the tumor seemed to have entirely absorbed the true uterine tissue with exception of the neck. In the body of the tumor were observed small masses or growths varying in size up to that of an egg. The ovaries were small and seemed to have participated in the general disease. Microscopic examination proved the tumor to be of the adenocarcinoma variety.

At first I was convinced that I had a case of extra-uterine pregnancy; but the peculiar hardness of the tumor made me doubtful. Here was a patient that had never had any uterine ailment. Marries, becomes pregnant; at the end of the third month, without any premonition, while quietly walking, is seized with pain of an excruciating nature in the right side, goes to bed and remains quiet; the next day blood flows from the vagina. She remains comparatively well for two and a half months more, when she is again suddenly seized with pain in the same side, followed by peritonitis. A tumor is found in the affected side, the uterus is enlarged, but not sufficiently so for a five and a half months' pregnancy, the os giving no signs of that softening which should accompany pregnancy. Could we have a group of symptoms more allied to those of extra-uterine pregnancy?

Dr. J. M. Keating made some remarks on

Infant Feeding.

He said: At my request Dr. Charles Potts has instituted a series of experiments which have a decided practical value, and we hope to present them to this society at an early date in full. I desire to place on record a statement of the results so far reached which appear to be interesting and important. The question often arises, is it of advantage or not for an infant to be partly nursed and partly bottle-fed? What action has milk upon starch, if any? To answer this the following tests were made: (1) Sample of milk composed of the milk of several women—a quantitative estimation of the sugar in it by Fehling's method showed 6.84 per cent. 10 cc. of this milk was then taken and $\frac{1}{2}$ grain of powdered starch added, allowed to stand at a temperature of 99° for thirty minutes, after which 5 cc. diluted with 45 cc. of distilled water was tested, and showed 8.62 per cent. of sugar. The other 5 cc., after standing sixty minutes, gave 9.09 per cent. (2) Another sample found to contain 7.14 per cent. of sugar had a $\frac{1}{2}$ grain of powdered starch, as in No. 1. In thirty minutes it gave 9.803 per cent. of sugar in 5 cc. The other 5 cc., after remaining sixty minutes, gave 8.62 per cent. Possibly part of the sugar deposited and was drawn off with the first 5 cc. (3) Another sample showed 6.32 per cent. of sugar, and after adding the starch as before, gave in the first 5 cc. 8.19 per cent. The next 5 cc. 7.93 per cent. These investigations showing that the women's milk gave an increase of sugar after digesting with starch.

Experiment (4) A sample of cow's milk was tested and found to contain 3.87 per cent. of sugar, to this was added a $\frac{1}{2}$ grain of starch to 10 cc. At the end of thirty minutes 5 cc. diluted with

45 cc. of distilled water, showed no increase of sugar. (5) A sample of cow's milk gave 4 per cent. of sugar, and was treated as before, but at the end of thirty minutes, and then sixty minutes, it gave the same result. (6) Another sample of cow's milk gave 3.703 per cent. of sugar, was treated as before with same amount of starch. In thirty minutes 5 cc. gave same result; in sixty minutes 5 cc. gave same result. These investigations showing that cow's milk gave no increase of sugar after adding starch. Does the acidity of cow's milk prevent the sugar change? Does the sugar change continue in an acid medicine? (7) Took another sample of human milk from one woman. It yielded 6.25 per cent. of sugar; added starch as before. In thirty minutes 5 cc. gave 7.14, and in sixty minutes 5 cc. gave 7.6 per cent. Took 10 cc. of this milk (6.25 per cent. sugar) and added a few drops of C. P. dilute hydrochloric acid, enough to faintly acidulate it, and then added $\frac{1}{2}$ grain of starch and let it stand as before. In thirty minutes 5 cc. gave 6.41 per cent., and in sixty minutes 5 cc. gave 7.35 per cent. of sugar. (8) Another sample of woman's milk without starch gave 6.17 per cent., with starch 7.24 per cent.; 10 cc. of the same, acidulated with hydrochloric acid, C. P., diluted, gave in thirty minutes 7.35 per cent. In these tests 10 cc. of Fehling's solution were used with 40 cc. of distilled water.

If future investigations prove the correctness of these statements, we may safely assert that the nursing woman may supplement her breast milk with some well-prepared digestible form of food containing a small quantity of starch advantageously, and also that the amylolytic ferment will remain active in the slightly acid stomach of the infant.

W. H. H. GITHENS, Secretary.

CHICAGO MEDICAL SOCIETY.

Stated meeting, June 15, 1885. The President, C. T. Parkes, M. D., in the chair.

A Successful Case of Nephrectomy.

Dr. R. G. Bogue reported an important case of nephrectomy. The patient was a woman, aged thirty-six, single, who had suffered from several attacks of acute rheumatism with cardiac complications and also for nearly one year with a pus-discharging sore on one arm. About six years ago, while doing laundry work, she severely strained her back, and this was followed by frequent and painful urination, the urine containing pus, blood and mucus. The pain in the back increased during menstruation. These symptoms continued until 1882, when a swelling, accompanied by pain and soreness, appeared in the right lumbar region. This swelling was finally opened and gave exit to a large quantity of pus, and remaining open, continued to discharge pus until the time of the operation, pus, blood, and mucus at the same time appearing in the urine, which was voided with difficulty. At one time there was so much clotted blood in the bladder it was only dislodged by breaking up the clot with a catheter and washing out the bladder. Later, there was nearly a closure of the opening into the lumbar abscess, and a fluctuating tumor appeared near the old one, which was opened and gave exit to a quantity of fetid pus. From May 13 to Au-

gust 27, 1884, there was a free discharge of pus through the lumbar openings and the bladder. At no time was there a urinous odor to the discharge from the loin. Whenever the discharge from the loin was greater, pus appeared in less quantity in the urine, and vice versa.

Believing that there was an abscess of the right kidney, on August 27, 1884, Dr. Boyne made an exploratory operation by making an opening into the loin along the course of and just below the twelfth rib, including in its track the sinus. He came upon a dark, fluctuating mass, which upon puncture, discharged a quantity of pus, and on further examination, was found to be the capsule of the kidney, divided into compartments and distended with pus. The sac was adherent to the surrounding tissues, and upon separation, bled freely. The adhesions were quickly broken up and a stout ligature placed around the attachment or peduncle, which was the ureter and renal blood-vessels. This was done by the aid of a large bent probe armed with silk. This ligature completely arrested the hemorrhage. Near this ligature the peduncle was transfixed by a double thread of strong silk and tied in two parts, the mass cut away, with ligatures left long, and with drainage-tube, served to drain the cavity, which was cleansed with a carbolated solution and the wound dressed with oiled silk, gauze, and oakum. The patient convalesced rapidly with the exception of an attack of rheumatism and one rather free discharge of blood from the bladder, which followed traction on the ligatures. The ligatures did not separate until December 7. But little pus came with the urine after the operation. There is yet a small fistulous opening in the track of the wound. The patient is now comparatively well. The mass removed was a distended kidney capsule, with calices so distended that there was obliteration of the kidney tissue, except at one point where there was enough to identify the structure.

Dr. C. T. Parkes remarked that an interesting point in the report is where it is described how hemorrhage was arrested, as the greatest danger in this operation is from hemorrhage. Czernay had a case in which the hemorrhage was so severe that he ligated the aorta. Operations on the kidney are becoming quite frequent. In an interesting paper Dr. Gross gives his observations of over 200 cases, and limits the cases in which an operation is suitable. Dr. Parkes said that he wished to call the attention of the society to the fact that there is sometimes an anomalous distribution of the arteries to the kidneys. He had met two cases in which the arteries entered the kidney at the lower end instead of the hilus, and this should be remembered in cases of nephrectomy, and especially nephrolithotomy. Sometimes the renal artery enters the kidney by two branches.

In answer to several questions by members of the society, Dr. Bogue replied that no vertical incision was necessary, that the diagnosis was positive only after the operation, which was an exploratory one, that the ureter and renal blood-vessels were ligated in mass, that in a supposed case, when there was a well-defined, movable tumor in the abdomen, unaccompanied by pain, pus in the urine, with difficult urina-

tion, which was relieved by washing out the bladder. If there was a reasonable probability it was a suppurating kidney, he would advise an operation.

The Continuous Curve Forceps.

Dr. E. W. Sawyer read an interesting and exhaustive paper on the continued pelvic curve in the obstetric forceps, with remarks on forceps in general. He defined the perfect obstetrical forceps to be an instrument with which it is practically impossible to injure the mother or fetus when skilfully used. In order that the forceps may be such an harmless extractor, after many years of observation and experience, he had arrived at the following conclusions: First, that there should be a space of three and one-fourth inches between compressing surfaces of the blades, when the inner surfaces of the handles are in contact. Any less space will fatally compress the foetal head. The long diameter of the ellipse bounded by the conjoined grasping curves of the blades should be five and one-half inches, the distal opening of this ellipse, corresponding to the separation between the tips of the blades, may be three-fourths of an inch; five and one-half inches from the blade tips the opening should be two and one-half inches. If these measurements are less, severe injury may result to the fetus. Second, in selecting an instrument a straight-edged ruler should be placed at right angles to the long diameter of blade, to determine if the outer edge of the blade and the border of the fenestra are on the same plane; if not, such an instrument invariably injures the foetal scalp. Third, the loose mortise joint lock, allowing a backward and forward motion of the handles, and thus enabling the obstetrician to properly adjust the forceps to the foetal head, is the only safe, simple, and easily operated lock. Fourth, in compressing the foetal head the closest imitation of nature is safest to follow, hence a moment of compression during a pain should be followed by loosening the grasp of the head, which cannot be done with those instruments which admit of the handles being fixed together. Fifth, the length of handles should be such as to allow the operator to reserve his forces for difficult traction. The rounded space just in front of the lock, admitting of the introduction of a finger, is of special value as a point of traction when a great degree of compression is not demanded. Sixth, the blades of the instrument should be of the best steel, at least one-fourth of an inch square at the shanks, and gradually thinned to about three thirty-seconds of an inch at the tips. Slighter material is so yielding as to permit the blades to be pulled off the head. Seventh, if an index be fixed to the foetal head, as for example the handles of a forceps, in such a manner as to follow the direction given to the head by the unaided efforts of nature, an irregularly curved line would be described forward and upward, which would have its termination, at the moment of the escape of the head, at a point near the umbilicus of the woman. This curved line should be the guiding line to the attendant who attempts to reinforce the expulsive force of the uterus with the forceps. Dr. Sawyer then exhibited a forceps of his own invention, in which the pelvic curve is extended to the ends of the handles,

to guide the operator in producing traction in the direction of the curved line above mentioned. He claimed that in those cases where the occiput, or sinciput, presents posterior, and it is decided to deliver in this position, this curve will allow the operator to grasp the head with the forceps well forward over the ears, without its slipping over the occipital poles.

In answer to several objections as to the feasibility of securing a perfect forceps, Dr. Sawyer stated that he did not claim his forceps to be perfect, but that he had copied the best features of

other forceps, and thinks that he has an instrument which will do less injury to the mother or child than any forceps with which he is acquainted. He believes it to be absolutely safe for the child, and was not intending to speak of the indications for using the forceps, or the manner of their use, but endeavored to incorporate in his paper some points about forceps in general which he had never read or heard taught, and hoped they would be useful to all who wished to approximate as nearly as possible the ideal forceps.

EDITORIAL DEPARTMENT.

PERISCOPE.

Hysteria.

Dr. Samuel Bell thus writes in the *Med. Age*:

Perhaps there is no disease which comes within the range of a physician's observation that taxes his resources, medical, moral, and social, any more than an obstinate case of hysteria. The premonitory symptoms in some cases will drive the ordinary diagnostician to his wits' end in order to satisfy anxious friends. Hysteria occurs most frequently in females between the ages of 15 and 24; exceptional cases occur later in life. Young girls, old maids, widows, and childless married women, are the most frequent subjects of the complaint. Charcot attributes great importance to ovarian hyperæsthesia as a cause of hysteria. The general system may be deranged by many conditions, but the sexual functions assume an undue prominence in the mind; consequently, any disturbance in connection with these functions produces an exaggerated effect. Hysteria is rarely found in the male. A semi-hysterical condition is found sometimes between the ages of 35 and 50 years. Among its causes may be mentioned excessive venery, masturbation, overwork, with long-continued anxiety, excessive and prolonged mental labor, and senile degeneration.

Prof. W. H. Thompson, of New York, recently related, during one of his excellent lectures on the above subject, his experience in connection with a case which is, perhaps, not altogether unique. The patient was a female of 20 years. After a careful examination a diagnosis of hysteria was made and appropriate treatment prescribed, with no apparent improvement of symptoms. The case was becoming monotonous to physician and friends. A noted metropolitan neurologist was called in consultation, and acquiesced in the diagnosis which had been made, also saying with emphasis, that any doctor with average knowledge would know that it was a case of hysteria. Ere the consultation closed, they were summoned to the bedside of their patient, only to see her expire.

I have had under my care during the past two months, a young lady 18 years old, stout and robust, well developed physically, and a person of average mental calibre. No history of any ab-

normal psychical manifestations previous to the present sickness. At my first visit I found her in a hystero-maniacal state, clonic spasms of the muscles of the cervical region, opisthotonos, strabismus, pupils dilated but would respond to light, general hyperæsthesia, with intervals of dysæsthesia; hearing very acute. A whisper would be heard by her in the remotest part of the adjoining room. Continuous vociferation, and persistent efforts to leave her bed and room, made it necessary to use force in order to keep her in bed. Pulse 100, temperature 2° above normal. Pulse full and compressible during the interval of spasm. Her exclamations frequently referred to her head. This symptom is considered by many pathognomonic of hysteria—*clavus hystericus*. It is described by some as if a nail were driven into the head.

Valerian, bromide of potassium, and chloral, were given, but hysterical vomiting began at once, and for a time the above remedies had to be abandoned. Large doses of morphia sulph. were given with some better results, but the raging delirium still continued, and one week elapsed before she recognized her condition, and then only for a few minutes. In three weeks she was able to sit up and walk around in the room, but a few days later all the former symptoms came back in an exaggerated form. After about twelve hours of raging delirium, she passed into a cataleptic condition, and remained so for a long time, all the vital powers seemingly in a state of suspension, except the heart and lungs; were it not for the action of the heart, which was performing its functions, the prognosis must of necessity have been grave.

The pain in the cranial region was a constant symptom throughout her illness. Cantharidal collodion blisters were applied to occipital and temporal regions and top of head, with some improvement in the pain. But change of surroundings and stern moral treatment seemed to exercise a marked beneficial influence upon the patient. The action of the heart becoming very feeble, with absence of the first sound, and palpitation, rendered the convalescence rather tedious.

To enumerate all the symptoms present would require too much space in your columns. Psychical, motor, sensory and sympathetic symptoms were all present, and very obstinate to control.

A snap diagnosis between epilepsy, multiple sclerosis of brain and spinal cord, hypochondria, neuralgia and uræmic coma cannot at once be made, on account of the variety of symptoms manifested. Especially is the diagnosis obscured when no history can be gleaned from patient or friends with reference to abnormal menstruation, which was no doubt the exciting cause. At times enough anodyne would be retained to produce somnia, but tonic and clonic spasms would continue during sleep with less severity, and would be greatly aggravated on waking.

A Case of Mole Pregnancy, Hydatid Mole, or more Properly Speaking, Cystic Degeneration of the Chorion.

Dr. Alexander Davidson reports this case in the *Canadian Practitioner*:

Mrs. W., æt. 45, of dark complexion, has borne several healthy children, last pregnancy was five years ago, when she was delivered of a healthy child; since then she has menstruated regularly until about the middle of January, 1885.

This lady consulted me on the 13th of March, 1885, complaining of being "completely out of sorts," had a constant feeling of nausea, her breasts were enlarged and painful, the areola around the nipple was quite dark in color, with raised papillæ on its surface, the veins over the breasts were very distinctly marked, she had not menstruated since 18th of January last and her tastes and disposition were quite changed; to use her own expression she said, "If it were not for my age I would consider myself pregnant again." Having assured her that although it was somewhat rare for pregnancy to occur at her time of life, yet her age was not an absolute barrier to the occurrence of conception, and her symptoms pointing so markedly to the existence of pregnancy, I deemed that to be her condition. I advised her to go home and wait the course of events, as there then existed no symptoms which should make me apprehensive of her case. Upon this advice she acted, again returning to my office on the 18th of March, when she informed me that since our last interview she had "turned unwell," and that she also observed a "lump" in the lower part of her abdomen, and suffered no pain. I then made a physical examination of the uterus, which revealed the following condition: The abdominal walls were thin and flaccid, just above and behind the pubes in the mesial line was a pear-shaped tumor to be felt; bi-manual examination now confirmed this tumor to be the uterus enlarged to about the size the organ assumes at the third month of pregnancy, the cervix was soft and thick, it was also fissured, the os uteri was patulous enough to allow the introduction of my index finger to nearly the whole length of the cervical canal; I could find nothing presenting. I may here mention that upon bi-manual examination the enlarged uterus seemed to have more of a soft feeling like a bag of bran than the firm resisting feeling of a truly pregnant uterus.

I now saw my patient from day to day until April the 11th, when the hydatid was expelled. The flooding continued at intervals, sometimes in small quantity, sometimes in considerable quantity, and sometimes absent altogether for as long

a period as twenty-four hours; the hemorrhagic discharge was not the thick red of normal blood, but seemed to consist more of the watery element of the blood, as if the liquor sanguinis had been expressed from the blood clotting in the interior of the uterus. No portions of the hydatid escaped with the hemorrhage, as sometimes happens in these cases, thus rendering the diagnosis easy.

The enlargement of the uterus was very rapid, reaching at the time of the expulsion of the hydatid as high up as an inch above the umbilicus, and measuring two inches in its transverse measurement. During the progress of the case I observed that the uterus was not steady in its enlargement, some days being somewhat reduced in size, and the next being again enlarged; this temporary reduction in size corresponded to the times when the flooding was most severe.

The pain at no time amounted to anything except at the termination of the case, when uterine action set in to expel the contents of the uterus.

The nausea was at times very severe. My reason for not exploring and emptying the uterus at an earlier period, was the fact that at no time did the life of the mother appear to be in jeopardy.

The point at issue here was the diagnosis. From my experience of this case, I would esteem the very rapid enlargement of the uterus, its soft and somewhat pulpy feel, and the character of the discharge, as very valuable signs in aiding me to a correct diagnosis of a similar case.

The Treatment of Cholera.

The *College and Clinical Record* says:

Professor Da Costa, in a lecture on this subject at the Jefferson Medical College, expressed the following views:

Prophylaxis.—Since filth of all kinds leads to a rapid production of the germs, the locality should be rid of the same. The dejecta and cesspools should be disinfected. Inspect the source of water supply, since the germs can obtain easy access to wells. Drink only filtered water. Speedy burial of the dead should be urged. No change in diet is necessary. Live as usual. Better avoid stimulus in the prophylactic treatment. Among the disinfectants to be used are corrosive sublimate, zinc chloride, cupric sulphate, iron sulphate, and permanganate of potassium.

Internal Treatment.—Must check the early diarrhoea if you desire to be successful, for, in most cases, if you stop this you put an end to the disease. For this purpose the most valuable are sulphuric acid in combination with tr. opii deod., with aq. menth. pip. In India the acetate of lead, grs. iv., with pulv. opii, gr. j., at once with the diarrheal outbreak, and continue every three hours until it checks the discharges. If the above cannot check the diarrhoea, use capsicum, gr. j., with opium and camphor.

Second Stage.—Here we have cramps, vomiting, and purging. Now, stop the use of fluids; allow but little ice in the mouth. This is a point of great importance. As little food as possible. Stimulus in small amounts, but frequently repeated. Mustard to the epigastrium. Administer, every hour or two—

R. Tinct. capsici, gtt. ij.
Tinct. opii deod., gtt. x.
Aque camphoræ, f. ʒij. M.

If stomach does not retain the opium, give it hypodermically; but, if possible, give it by mouth, since it appears to have a local effect. To relieve the cramps, use chloral subcutaneously, in large amounts. When reaction has set in, allow fluids to wash out the kidneys. If he has not reacted, and is not doing well under opiates, try calomel, especially in cases in which the secretions have not been arrested by opium. Give at first gr. v. to gr. x., then order gr. ʒ every hour or so. When the pulse is sluggish, the temperature below normal, use friction and a hot bath. In this, the stage of collapse, stimulus will not be absorbed or it would be of utility, though brandy or whisky might be tried hypodermically.

Caffeine, gr. iss.—gr. ij., hypod., stimulates the heart's action. If still the patient fails and the veins are swollen, etc., resort to blood-letting, but possibly the injection of fluids into the veins is better; often the results are marvelous. The thickened blood is made to circulate. Use for this purpose the following:

R. Sodii chlor., ʒj.
Sodii carb., ʒij.
Aque, Ovj. M.

Get it up to 106° Fahrenheit and a specific gravity of 1.005.

Sig.—Throw in a few ounces at a time, until forty ounces have been injected. When the patient again flags, throw in a like amount.

The inhalation of oxygen has done no good.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—The treatment of hay fever is discussed in a reprint by Dr. J. A. Stuckey, of Lexington, Ky. He relies on the local use of chromic acid and cocaine.

—The management of the abscesses in hip disease is explained in a paper of Dr. A. B. Judson's. His recommendations in general are as follows:

1. The increased vascularity attending inflammation in the tissues of the joint requires arrest of motion in the joint, or fixation.

2. The softening of the bony tissue and its increased fragility require that the joint be relieved from the weight of the body in standing, and the direct concussion transmitted up through the long bones of the limb from the heel in walking and running.

3. As the cure is to come by natural processes, it is important that the general condition be kept at the highest possible point of excellence. The patient should, therefore, be active out of doors, and enabled to follow the ordinary pursuits of his time of life.

From the same writer we have received a useful article on "The Mechanical Treatment of Talipes Calcaneus."

—An article on fungous endometritis, by Dr. James B. Hunter, of New York, contains an instructive synopsis of the pathology, diagnosis, and treatment of this troublesome disease.

BOOK NOTICES.

A Treatise on Asiatic Cholera. Edited by Edmund Charles Wendt. Illustrated. New York, Wm. Wood & Co.

This is a combination volume, prepared by Drs. John C. Peters, Ely McClellan, John B. Hamilton, and Geo. M. Sternberg, with the editorial services of Dr. Wendt. It presents a history of the disease; a discussion of its etiology; its symptomatology, course, and sequence; its morbid anatomy, diagnosis, prevention, and treatment. It is a useful digest of the subject. The volume is one of the series of "Wood's Library of Standard Medical Authors."

Medical Thoughts of Shakespeare. By B. Rush Field, M. D., Member of the Shakespeare Society of New York. Published by Andrews & Clifton, Easton, Pa. Pp. 86. Price 75 cents and \$1.

Dr. Fields' essay is a creditable study of the great bard from his medical side. All the allusions in his writings which bear upon anatomy, physiology, medicine, or the kindred sciences, are carefully culled from his pages and discussed. Both to the physician and the Shakespearean student, the essay is interesting.

The Ten Laws of Health: or, How Diseases are Produced and Prevented, and Family Guide to Protection Against Epidemic Diseases and Other Dangerous Infections. By J. R. Black, M. D. Cloth, 8vo., pp. 413. Price, \$2.00. Philadelphia, J. B. Lippincott & Co.

In the publication of this work the author has contributed an aid of no little value to the sanitary improvement of our country. Addressed to the intelligent public, it is written in a clear and attractive style, and sets forth in an impressive manner the importance of health and the means of preserving it. These include both the positive admonitions of pure air, proper food, and the like, and the negative warnings of what to avoid, what to prevent, and what precautions should be observed in infectious diseases, and unwholesome seasons and climates. The general distribution of such a work cannot fail to increase the happiness of a community, by teaching them those principles of action most conducive to health and activity. The author has conferred a benefit on the public by putting these principles in such an accessible form.

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**THE INFLUENCE OF HIGH ALTITUDES UPON
 PULMONARY CONSUMPTION.**

Dr. Austin Flint, so says Dr. J. M. Snow, in the *N. Y. Med. Jour.*, June 13, 1885, states that he has seen but seventy-five cases of phthisis in which an arrest of the disease took place, and in most of these the improvement was for a short time. When we realize that one-seventh of all deaths are yearly attributed to this cause in the United States, and in Maine fifty per cent. of all deaths between twenty and forty years are from consumption, it behooves us, knowing this failure of the materia medica to cope with the disease, to give our attention to the modifying influence of climate upon chronic pulmonary disorders.

That climate is a potent agent in the prevention of phthisis is demonstrated by the fact that a region of comparative immunity from this disease is found in high altitudes. Consumption is very rare among the native population of New Mexico; and it is stated by Dr. Archibald Smith to be an exotic in the Peruvian Andes at an elevation of 6,500 feet. Küchenmeister and Lombard have estimated the altitude of approximate immunity in Switzerland at 4,000 feet, and at the equator at 9,000 feet. We may see the influence of altitude in our own country: that while the mortality in New York City is 20 per cent., at an elevation of 2,000 feet it is only 10 per cent.

Dr. Denison, of Denver, has placed the altitude of comparative immunity at 6,000 feet; the vital statistics of Denver in four years and a half show but fourteen deaths from phthisis originating in the state.

Damp, ill-drained land, cold, humid air, sudden changes of temperature, lack of sunlight, anti-hygienic surroundings, all contribute to depress the general health, and to occasion the fearful prevalence of phthisis in low-lying districts and in large cities. When in search of a climate for the prevention or cure of consumption, dryness of air and soil, and the invigorating influences of sunlight, must be among the deciding factors.

When we learn that the difference between the annual precipitation of rain and melted snow at Denver, 5,300 feet above the sea, is 14.77 inches

as compared with New York, where it is 42.70 inches, we can appreciate one of the causes of large cities presenting such large phthisical mortalities. Constant humidity of earth and air predisposes most strongly to the development of phthisis; dryness of soil and atmosphere gives to the inhabitants of high plateaux comparative exemption from disorders of the respiratory tract. Laennec mentions a locality where the dampness of the soil was of such a character that two-thirds of the resident population died of phthisis.

The effect of light is to stimulate respiration, and to the consumptive, whose hope of life depends upon the amount of sunlight and out-door exercise he can obtain, the value of a climate like, say, Colorado, may be appreciated when we contrast its 320 sunny days annually with Boston, where one-third of the year is cloudy.

The atmosphere becomes cooler in proportion to the elevation above the sea, 1° lower for every 200 feet; physiologically heat is opposed to stimulation of the nervous centers, its influence upon respiration is also depressing.

Dr. Parkes shows that the number of respirations in the tropics is about 13 to the minute, in England it is 16½. The value of a cool climate in arresting incipient phthisis is well known.

NOTES AND COMMENTS

Treatment of Gastric Affections.

That muriatic acid has a beneficial effect in many cases where gastric digestion is disturbed is a fact generally appreciated. Dr. S. Talma (*Ztsch. f. klin. Med.*, viii., p. 407,) has recently investigated the action of this acid in cases of dyspepsia depending upon abnormal fermentation. He recommends to administer the acid only so much diluted as it is met with in the normal gastric juice, viz., 1 part to 750 of water, and to use at least sixteen minims of it (the undiluted acid) during twenty-four hours. T., however, mentions that there are some cases where apparently an abnormal decomposition of the contents of the stomach exists; the patients—generally nervous women—complain of acidity and gastralgia, sometimes of a severe character, after meals. In these cases the muriatic acid is not only without effect, but it even does harm, while an alkaline

treatment at once improves the morbid symptoms. The mucous membrane of the stomach seems to be very sensitive to the influence of muriatic acid. Whenever dyspepsia appears in connection with cerebral anemia, or when the former seems to be the direct consequence of the latter, nitro-glycerin has been found by Talma to have a very beneficial effect. He administered this powerful drug three times daily—immediately after the main meals—in the dose of one-third of a milligram = $\frac{1}{150}$ grain each.

We cannot see how a treatment can be successful which is not directed against the main causing element. When cerebral anemia is present, the dyspepsia is directly produced by it, and nitro-glycerin, at best, can only have a palliative effect by inducing a transient increase of flow of arterial blood to the brain. The object of the treatment in such cases should be the removal of the cerebral anemia; if this can be achieved, the gastric symptoms will cease by themselves.

Septic Poisoning Caused by the Watery Discharge from the Bowels of a Dead Subject.

Too great emphasis cannot be placed upon the importance of having the hands perfectly free from abrasions of the skin, or sores of any description whatever, by persons who have the handling of dead bodies, whether it be in holding post-mortems, or simply dressing the dead preparatory to burial.

To illustrate this forcibly, Dr. W. H. Tate reports the following case in the *Peoria Med. Mo.*, May, 1885:

On February 24, 1885, whilst Mrs. G., an old lady who died of apoplexy, was being washed for interment, one of the ladies who was present was called upon to assist in cleaning the body, and having previously a small scratch on the ring finger of her right hand, but not regarding it, happened to get some of the watery discharge that flowed from the bowels of the subject, into the abrasion. On the following day it was observed that the finger had assumed a red appearance, and also slight pain or smarting. In a day or two more the pain and redness had increased to an alarming extent, extending as far up as the shoulder and back of the neck.

Having poulticed it with various kinds of poultices, and getting no relief, after a delay of three or four days, Dr. T. was requested to prescribe for the hand. He ordered a flaxseed meal poultice to be applied, saturated with a ten per cent. solution of permanganate of potash, which was kept up for several days.

Good results were manifested after the second or third application, and in a week or ten days the hand was restored to its former condition and usefulness.

Glycosuria in Phthisis.

A point that will prove interesting to observe, and one that may ultimately lead to some practical therapeutic results, if a sufficient number of observations are recorded, is suggested by a short communication from Dr. M. Greenwood in the *Brit. Med. Jour.*, June 13th. He says:

For some time past I have frequently found sugar in the urine of phthisical patients. At first I thought this was but a coincidence, but latterly have begun to ask myself the question whether, in advanced phthisis, sugar is not invariably present in the urine. During the last three months, of five patients who died with this disease, I only failed to find sugar in one case, and in that there was probably extensive kidney-disease, as was shown by dropsy with albuminuria. The test I have always employed has been Fehling's, and the chief disturbing element in my analyses has usually been the presence of abundance of lithates. My results, however, I have often checked by testing in the same way some other sample of urine rich in lithates, where I did not suspect sugar, and comparing carefully the results obtained from each. I have referred to numerous works on medicine, but can find no account of any glycosuric tendency in phthisis, so that I should be glad to learn if my observations that have been noted previously, are merely accidental, or the results of error in analysis.

I may add that I have often discovered sugar in the urine in cases of respiratory embarrassment from acute pulmonary disease, as, for instance, in severe cases of bronchitis, and in pleurisy with effusion. In these, however, there has always been an excess of lithates.

Eczema of the External Ear.

Dr. W. R. Amick tells us in the *Cincinnati Med. Jour.* that in these cases the first thing to be done is to cleanse the parts thoroughly and remove the crusts. It is damaging to the physician's reputation, and useless to the patient, to make the applications on these crusts. We might as well place the salve on the boot over the location of the callosity on the toe, and expect the corn to be removed. We can not please the officials by patting the custom-house. They expect something more substantial, situated a little nearer at

hand. We must locate our treatment closer to the seat of the disease than the top of these concretions.

In children these crusts are best softened by the use of a poultice, or of cotton wet in warm water. The object is to keep some moist and warm substance in contact with the crusts until they are softened. After they have been removed a good and convenient application is boric acid and vaseline, in the proportion of one part of the former to four of the latter. If this causes pain or irritation, you may suspect impurities in either the acid or the vaseline. This application, even without internal treatment, will frequently relieve the smarting and irritation that comes from the abrasions upon the auricle and side of the face, and cure the disease. It must not be forgotten that the most important factor is *thorough cleansing of the diseased parts* before the applications are made.

Unusual Case of Fatal Peritonitis.

The following case, which Dr. Norman Reid reports in the *Brit. Med. Jour.*, May 30, 1885, is sufficiently out of the ordinary run to warrant reproduction:

At 10 p. m. he was summoned to a man, with the following history: He was fairly temperate in habits, and had always enjoyed good health, with the exception of a slight attack of dysentery three years ago; he, however, since suffered from dyspepsia and constipation, necessitating care in his diet. He had, a short time before he saw him, eaten freely of veal, mince pie, plum pudding, etc.; and, shortly afterwards, was seized suddenly with intense pain in the abdomen. When he saw him, he was doubled up in great agony, and pressing his abdomen. Examination revealed nothing save great pain and tenderness in the umbilical region. He gave an inhalation of chloroform, and a hypodermic injection of half a grain of morphia. The next morning, when he saw him, he had symptoms of peritonitis; he died the same evening. The necropsy showed three strictures of the small intestine (jejunum): in front of the third was a perforation at the site of an old cicatrized ulcer. Through this perforation, about a dozen currants had escaped into the peritoneal cavity. The case is interesting from the difficulty of making an immediate diagnosis, and also from the unusual position of the ulcers and strictures. It would be interesting to know, if this lesion could have been diagnosed, what good, if any, might have been done by abdominal section.

Desquamation in Scarlet Fever.

Mr. George Smith states in a note in the *Bristol Medico-Chirurgical Journal*, that he has for several years been in the habit of having his patients sponged over the whole surface of their bodies twice a day—commencing, as a rule, about a week from the appearance of the eruption, and continuing the process until desquamation is complete—with a mixture of one ounce of oatmeal to one pint of boiling water. The solution must be made fresh every day, and used tepid, or at such a temperature as may be comfortably borne by the back of the finger. His reason for using this particular form of scalded, not boiled, oatmeal, is that the gluten in it sticks the scales to each other and to the surface of the body, thus allowing their removal, from one sponging to another, without the ordinary risk of infecting either atmosphere or clothes, and greatly lessening the risk of spreading the disease. Secondly, this same gluten fills up the cracks of the new skin and protects it from cold, as, patch after patch, it becomes bare, and thus greatly lessens the risk of the dropsy which often follows this disease.

Potassium Permanganate Baths.

In June, 1879, a well-developed child, two years of age, was brought to Dr. Hüllmann (*Archiv. für Kinderheilk.*, Band vi., Heft 3), covered with eczema and impetigo. He had been sent from Berlin to Halle to try the baths there, but after three weeks he was worse instead of better. He was therefore prescribed an immersion-bath of permanganate of potash, of the strength of fifteen grains to a pail of water, the child to remain in it until the fluid began to turn brownish. Fourteen days afterwards he was cured. Since then, Dr. Hüllmann has used the remedy both in adults and in children, and mostly with good effect. He has not confined its use to eczema, but has employed it also in prurigo, intertrigo, and the desquamating stage of measles, scarlatina, and varicella. When the skin is much covered with scales or scabs, it should be well brushed with soap-and-water first. For convenience of use, he keeps a concentrated solution made with hot water.

The Intravenous Injection of Milk.

That we may have a clear and definite idea in reference to this therapeutic procedure, we quote the conclusions of an excellent paper on the subject by Dr. Charles E. Jennings, in the *Brit. Med. Jour.*, June 6, 1885:

1. The intravenous injection of a small quantity of newly-drawn milk is harmless.
2. Large injections of milk are fatal, with polyuria as the chief symptom.
3. The employment of impure or stale milk is most dangerous, on the probability that septiciæmia will follow the operation.
4. The operation is to be recommended in the later stages of cholera, enteric fever, phthisis, and pernicious anæmia, as a substitute for the transfusion of blood; and, in short, in all cases where transfusion of blood is indicated on nutritive grounds, but where a blood-donor cannot be procured, or where this operation is, for other reasons, impracticable.

Cocaine in Opening Buboës.

A correspondent reports this case in the *Med. Age*, May 25:

"G. L., æt. 35, had syphilitic bubo, leaving extensive sinuses, which ran in different directions down the thigh. Time gave no indication of their closing, and I concluded to open them. The party did not bear chloroform, and it was decided to give cocaine a trial. A four per cent. solution was injected into the fistulous canals and held there about five minutes. The effect was elegant. Where pain was excessive from exploring with a slender probe before using the cocaine, after using I passed a grooved director without sensation, and the knife caused the smallest possible amount of pain—"less than a pin scratch," to use the words of my patient. I opened up between eleven and twelve inches of fistulous canals."

SPECIAL REPORT.**OPHTHALMOLOGY.—NO. XIX.**

BY CHAS. S. TURNBULL, M. D.,
Of Philadelphia.

(Concluded from page 24.)

Glascott. *Case of Traumatic Aneurism of the Left Orbit Cured by Compression of the Carotid Artery of the Same Side.* Oph. Rev., vol. ii., p. 193.

Glascott describes a case in which exophthalmus followed a blow on the left side of the head. A large, strongly pulsating vessel was discovered at the inner and upper angle of the orbit. A murmur could be perceived isochronous with the cardiac systole. Compression of the left carotid, performed by the patient himself, with the assistance of a suitable compress, caused the exophthalmus to disappear in three weeks.

Noyes. *Ocular Tumors*. Transact. Am. Oph. Soc., 1882.

Noyes removed a spindle-cell sarcoma which originated from the periosteum of the orbital floor, and extended to the inner half of the lower lid and the conjunctiva of the lower part of the globe. The eye was preserved, with a moderate amount of vision. A relapse occurred in the præ-auricular region, and the patient died in six months.

Lubrecht. *A Case of Pulsating Exophthalmus*. Deutsche Med. Wochens., 1883, No. 35.

Lubrecht saw an exophthalmus develop in the right eye of a man, aged forty-nine, after a severe fall upon the head. Pulsation synchronous with the cardiac systole was noticed. No murmur could be heard by auscultation. The exophthalmus disappeared after ligation of the common carotid.

Eales. *Unicocular Reflex Iridoplegia Associated with Necrosis of Orbital Roof of the Same Side, with Double Optic Neuritis*. Oph. Rev., vol. ii., p. 225.

Eales observed double optic neuritis and fluctuating swelling above and to one side of the right eye, after a violent blow upon the right temple. The spot was incised, and a piece of bone as large as a quarter of a dollar, and belonging to the external angle of the superior orbital roof, was removed. A fistula soon formed in the neighboring bone, and the neuritis gradually but surely retrograded.

Sedan. *La Tenovite Rheumatismale*. Rec. d' Oph., 1883, 337.

Sedan observed an enormous swelling of the lids in a patient who suffered from rheumatism, and who applied to him at first for violent headache without any visible alterations in the eyelids or globe. He scarified the lids at the external commissure, and saw a decided improvement, after persistent slow exudation of a serous fluid.

Gradenigo. *Massage in Ocular Therapeutics*. Annali di Ottal., vol. xii., 1.

Gradenigo resorts to massage not only in diseases of the lids, but in those of the eyeball which are associated with increased intra-ocular pressure. Massage was of great help to him, in addition to other cases, in a case of severe tenonitis, in which the eyeball protruded to a marked degree, and was totally immovable, the cornea had lost its sensibility, and the retina even quantitative perception of light.

Bono. *Rare Cases of Transmission of Blennorrhagia to Eyes*. Gaz. delle Cliniche, vol. xix., p. 14.

Bono reports three cases of blennorrhœa of the conjunctiva in adults who had been infected by a

third person. The first case was that of a young lady who kissed and embraced, after a long absence, a brother who was suffering from blennorrhœa of the urethra; the second was that of a boy who slept in the bed of a patient suffering from gonorrhœa; whilst the third was that of a workman from whose eye a friend, affected with gonorrhœa, removed a foreign body.

Simi. *On Purulent Ophthalmia*, Annali di Ottal., vol. xii., p. 1.

Simi has tried every one of the antiseptics recommended of late years for suppurative inflammation of the conjunctival sac, and speaks very favorably of resorcin, because it not only acts antiseptically, but has the least chemical action upon the tissues of the eye. Nevertheless, the results which he has had with antiseptics of all kinds are not one whit better than those obtained with the old classical treatment of silver nitrate.

Panas. *Conjunctivite Rheumatismale*. Acad. de Méd., May 1, 1883.

Panas believes that cases of rheumatic conjunctivitis, such as Perrin describes, are to be accepted with a great deal of reserve. For himself, he has never seen any such cases. The purely rheumatic forms are very benignant; in malignant forms we ought to be able to exclude blennorrhœa and granulations.

Perrin. *Conjunctivite Purulente*. Bull. de l' Acad. de Méd., Nos. 16-19, 1883.

Perrin answers Panas by reading the history of a case carefully observed by De Belval, of purulent rheumatic conjunctivitis in a young man, without any granulations.

Robert. *Conjunctivites Catarrhales avec Arthrites Consécutives*. Rec. d' Ophth., No. 7, 1883, 311.

Robert describes six cases he had observed within thirty-three days, in which an acute conjunctivitis was followed by an affection of the joints which bore great resemblance to arthritis blennorrhagica. The particular type of disease is developed during very damp weather, in persons that are predisposed to arthritis by reason of their lymphatic diathesis and hereditary influences.

Diphtheritic Conjunctivitis, according to Potu. Thèses de Paris, 1883, is simply the ocular expression of a constitutional affection. A conjunctiva affected with catarrh or blennorrhœa offers only a place of less resistance upon which the general constitutional affection can spread itself. Pain is generally absent in diphtheritic conjunctivitis; if it should, however, be present, it indicates that the globe itself is also affected. The treatment consists in local cold, and the exhibition of tonics.

Goldoni. *A Case of Diphtheritis of the Conjunctiva and Tonsils, together with Facial Erysipelas, Promptly Cured by Salicylic Acid.* Gaz. d' Ospit., anno iv., No. 33.

Goldoni treated a case of diphtheritis in a man at thirty-two years, with large doses of salicylic acid and local cleanliness alone. The disease, which developed itself in the eye and then affected the throat, and to which facial erysipelas associated itself on the third day, reached its acme on the sixth day, and had wholly disappeared on the eleventh, without leaving any trace whatsoever on the cornea.

Talko. *The Caustic Action of Calomel upon the Conjunctiva. Hemorrhages from the Conjunctiva.* Medicum, part xi., 1883. Goldscheider. Berlin Klin. Wochenschr., 1883, 42.

Talko and Goldscheider report several cases of caustic action after insufflating calomel into the conjunctiva. Goldscheider cannot offer any explanation for so rare a result. But he suspects that calomel in connection with the sodium chloride in the lachrymal secretion may exert a caustic action.

(It is a well-known fact that most samples of calomel contain more or less free corrosive sublimate, and this it is that has a caustic effect upon the eye, especially when carelessly dashed into the eye in lumps, instead of being insufflated as a powder.—C. S. T.)

Sattler. *The Jequirity-Ophthalmia, a New Infectious Disease.* Wiener Med. Wochenschr., 1883, Nos. 17-21. Klin. Mon. f. A., Band xxi, page 207; Annal. d' Ocul., tom. xc., page 29.

Sattler examined the ophthalmia produced in man and rabbits by the jequirity seeds, and found that it differed in remarkable and essential points from any other artificial inflammation. The ophthalmia bears the greatest possible resemblance to an acute infectious disease, and approaches in many respects acute conjunctival blennorrhoea, particularly those severe types in which the conjunctiva is grayish, and exhibits a surface covered with a coagulable exudation.

Selitzky. *Iodoform in Trachoma.* Med. Wjestnik, Nos. 17 and 18.

Selitzky recommends the use of iodoform in ointment form in trachoma; he also uses other remedies at the same time. Under this treatment he has seen trachoma entirely disappear.

Pereyra. *On Some Therapeutic Uses of Iodoform.* Le Spérimentale, anno 37; fasc. 3.

Pereyra has employed iodoform, pulverized and in ointment (1 to 5), in more than 100 cases. Its action is not satisfactory in conjunctival affec-

tions; it has no influence upon pannus, but in ulcers of the cornea it is of the greatest value. The author asserts that iodoform also possesses a myotic action, diminishes intra-ocular pressure, without, however affecting the accommodation. Two cases of chronic glaucoma with inflammatory relapses were cured by iodoform treatment, i. e., the pain decreased and the eye became more quiet.

Saltina. *Iodoform in Ocular Therapeutics.* Gazz. d. Ospit., anno iv., Nos. 48, 49, and 51.

Saltina also used iodoform in phlyctenular conjunctivitis, blennorrhoea neonat., in trachoma, pannus, etc., but did not obtain any remarkable results. This remedy is most valuable in corneal ulcers. Although Saltina was enabled to achieve unexpectedly brilliant results in four severe cases of hypopyon-keratitis, he does not regard iodoform as the sovereign remedy in this form of disease, and believes that he could have obtained the same results by other methods of treatment. Iodoform has no value in parenchymatous keratitis.

Vassius. *On the Use of Iodoform in Ophthalmic Practice.* V. Graefe's Archiv., band xxix., 1, p. 297.

Vassius recommends iodoform in all ulcerative processes of the cornea, especially in ulcus serpens; also in all superficial and deep injuries of the conjunctiva and cornea; finally as an antiseptic in wounds of the sclerotic.

Alker. *On the Therapeutical Value of Iodoform.* Inaug. Dissert., Giessen., 1883.

According to Alker, iodoform is well borne by a majority of patients. It is of especial benefit in all ulcerative processes of the cornea, particularly in the infectious forms of hypopyon-keratitis, although there are cases in which neither iodoform nor Saemisch's operation can prevent total supuration of the cornea. Iodoform is of great value, not only as an antiseptic, but also as an aseptic in all fresh injuries. It frequently clears up the cornea in the most brilliant manner in scrofulous and deeper-lying corneal infiltrations.

Galezowsky. *Iodoform dans les Ulcères Rougeants de la Cornée.* Rec. d' Ophth., 1883, p. 348.

Galezowsky advises the use of iodoform ointment in the treatment of most ulcers of the cornea. At the same time, however, the usual remedies are to be employed—atropia, eserine, etc. Several cases are described.

Makrocki. K. M. f. A., Band xxi, p. 329.

Makrocki describes *Three Cases of Extraction of Cysticercus from the Subconjunctival Tissue in Children.* The capsule of the cysticercus was found

to consist a framework of connective tissue composed of thick fibres of connective tissue, running lengthwise, and crossed by elastic fibres. The outer and inner surfaces were partially covered with a capillary mesh-work, which was rich in anastomoses. The external surface showed considerable endosmosis and exosmosis of white blood-corpuscles, which, toward the inner surface, had been transformed into epithelial cells.

Creus. *Operation for Pterygium*. Eco de la Clinica, 1883.

Creus operates upon pterygium by loosening the vertex as far as 3 mm. beyond the margin of the cornea, then turns the vertex over to form a duplication in such a way that the two bleeding surfaces touch. So soon as they are accurately adjusted, sutures are applied.

Couzon. *Contribution à l'étude de la Keratite Interstitielle dans la Syphilis Héritaire et dans la Syphilis Acquise*. Thèse de Paris, 1883.

Couzon asserts that interstitial keratitis is a frequent result of congenital syphilis, while occasionally it is seen in acquired cases of this disease. Rheumatism may also excite attacks of interstitial keratitis.

Martin. *Sur le Rapport qui Existe entre Une Variété de la Keratite Grave, dite Scrofuleuse et l'Astigmatisme de la Cornée*. Annal. d'Oculistique, Tom. xc., p. 14.

Martin brings forward a new form of keratitis, which he calls astigmatic keratitis. We frequently see in scrofulous persons, between the age of six and twenty, an extremely obstinate keratitis, which is due, as Martin insists, to a corneal astigmatism. Any corneal astigmatism is corrected by varying degrees of accommodative energy in the two main axes; but this very energy, according to Martin, produces the corneal inflammation. Astigmatism, therefore, is the cause of corneal affection, and the author endeavors to prove the fact. In order to cure the keratitis, the accommodation in both eyes must be paralyzed. Relapses can be prevented by furnishing proper correcting glasses, while in the very same way the appearance of astigmatic keratitis can be prevented.

Frank. *Case of Partial Keratoconus, with a Remarkable Change in the Refraction Following an Injury*. Maryland Med. Jour., September, 1883.

Frank reports the following case: The patient ran against a ladder. The globe was ruptured at the sclero-corneal margin, and a hernia of the iris ensued. This was removed close to the globe with scissors. The refraction of the eye then began to alter, and finally sight became $\frac{3}{8}$ with $+\frac{1}{2}$

sph. \ominus $+\frac{1}{2}$ cyl. axis 56°. The author would thus argue in favor of iridectomy as a remedial measure in keratoconus.

Hirschberg. *On Congenital Pigmentation of the Sclera, and its Pathogenetic Significance*. V. Graefe's Archiv., Band. xxix., 1, p. 3.

Hirschberg publishes three cases of melanosis of the sclera, in two of which the eye had to be removed on account of an intra-ocular tumor. In his opinion, melanosis of the sclera indicates a certain predisposition to subsequent development of a tumor in the eye, just in the same way as congenital pigmentation of the skin may, in old age, form the starting-point of melanotic growths.

Higgins. *Gummata of the Sclerotic*. Brit. Med. Jour., February, 1883, p. 247.

Higgins reports three cases of gummata of the sclera. The first one recovered after a treatment of several months' duration. In the second, the tumor covered both the inner and outer surface of the sclera, and had caused detachment of the retina. The third resisted treatment for a long time.

Hirschberg and Birnbacher. *Congenital Lipomatous Dermoid, in and behind the Equatorial Region of the Eyeball*. C. f. A., 1883, Band vii., p. 295.

Hirschberg removed from the lateral portion of the sclera a tumor 18 mm. long, 10 mm. broad, and 7 mm. thick, which proved to be a dermoid tumor with fatty tissues in the deeper layers.

Danesi. *Coloboma of the Iris*. Boll. d'Ocul., vol. v., 9, March, 1883.

Danesi describes a congenital coloboma of the iris in which the corresponding portion of the ciliary processes was also absent. The choroid was intact, but numerous deposits of pigment were found in the fundus. V. = $\frac{1}{2}$ with -20.

CORRESPONDENCE.

Depressed Fracture of Ribs, with Wound of the Diaphragm and Left Lung.

EDS. MED. AND SURG. REPORTER:—

Reading the report in the last polyclinic by Dr. Forrest Willard, M. D., of fracture of ribs with wound of liver, lung, and diaphragm, has induced me to submit the following case. I regret an autopsy was refused, hence my diagnosis was not confirmed.

June 1, 1885, was called to see J. G., colored, aged forty-five years, weight 170 pounds, who had just fallen a distance of twenty feet, striking upon a pile of lumber. Upon examination, found fracture of seventh and eighth ribs on left side, and fracture of two metatarsal bones. Patient in profound shock. Morphia and ether administered hypodermically. Ordered him removed to his

home, where I saw him one hour later. Slight reaction had taken place; dyspnoea was alarming; great pain in epigastrium, with marked retraction of the abdominal wall. Stimulants and opiates administered freely. At four o'clock p. m., six hours after injury, there was full reaction; pulse, 120; temperature, 100°. Physical examination revealed pneumothorax, together with considerable hemorrhage into the pleural cavity, gurgling rales, and well-marked metallic sound.

There was some tympanites, patient expectorating bloody mucus, nausea and hiccough distressing. Diagnosis—Fracture of seventh and eighth ribs, with slight depression of outer fragments, wounding the diaphragm and penetrating the pleural cavity, entering the base of the lung. Treatment.—Morphia hypodermically, and chest bandage.

June 2, 7 a. m., breathing not so labored, tympanites increasing, vomiting relieved, pulse 125, weak and gaseous, temperature 102°. 12 m. No appreciable change. 7 p. m. Consultation held, agreed upon the above diagnosis, beef and whiskey enemata suggested and prescribed, digitalis given by mouth, but rejected.

June 3, 7 a. m. Tympanites still increasing, pulse feeble, active stimulants administered by rectum and hypodermically. 12 m. Pulse 100, and stronger than at any time since the accident, hiccough annoying, no other change remarked. 6 p. m. Patient died suddenly.

The symptoms leading me to diagnose wound of diaphragm were hiccough, pain in epigastrium, marked retraction of abdominal walls at first, and subsequently tympanites.

RICHARD DOUGLAS, M. D.,

Nashville, Tenn.

NEWS AND MISCELLANY.

The Kentucky State Medical Society.

PROCEEDINGS REPORTED BY ALLEN KELCH, M. D.

The Kentucky State Medical Society held its thirtieth annual meeting at Crab Orchard Springs on the 24th, 25th and 26th of June. The attendance was large, and the meetings full of interest.

The regular order of proceeding was begun by the report of the Committee on the Practice of Medicine, Dr. Wm. Bailey, of Louisville. After a few introductory remarks, Dr. Bailey spoke in substance as follows:

"In the first place I will mention my experience (I suppose it is likewise the experience of all of us) in having my office table cumbered with new preparations in pharmacy. I think this has been carried to an extent that has necessarily made it a nuisance, and that it has utterly failed to meet the purposes of those who have distributed them. I confess, at the beginning, that I have not had the courage to even uncork a tithe of them, and have become familiar with scarcely any of them. I think that the principle as well as the practice is at fault. It occurs to me that the cart is before the horse; that the physician should go before, and, after proof of value, demand of pharmacy certain preparations of drugs, or certain combinations of them eligibly prepared, instead of having them urge you to prescribe medicines prepared by

their formula. It seems to me to be more of commercial policy prompting the multiplication of these new remedies than either necessity or convenience. I may be mistaken, but I am inclined to the belief that the other course would equally redound to the material interest of those who are thus concerned. I would ask you what proportion of these preparations that have been so widely dispensed in the last five years are now among the reliable means of combatting disease? An evil accompanies the method that is inseparable from it. The tendency is to induce the people at large to buy and take these preparations without medical advice. It fosters a disposition altogether too general of indiscriminate medicine taking. I would suggest that if an enterprising firm desires to put before the world a new remedy of value that it would be better for all concerned to have it placed in sufficient quantity to be used by public institutions, at the hands of competent men, to note and record its effects in a large series of cases, so that the practitioner might have some reason for confidence in its administration.

"In this way the good will not suffer loss and the useless will not disappoint. Too many of us, I suspect, are daily watching the medical journals for our prescriptions, hoping to get the reliable to replace that which has failed us. Would not this in the long run even pay those engaged in manufacture?

"I do not wish to underrate the importance of pharmacy or decry the effort being made to render medicines more elegant or eligible in preparation, for I think much has been done in this line and still much remains to be done.

"You might answer that all of these come to us accompanied by a long list of testimonials. True, but we know how and from whom such testimonials are obtained. No doubt to some it is flattering to their ambition to be approached, with the statement that testimonials are wanted only from the leading men in the profession, and others are delighted to see their names in print, scattered broadcast over the entire country.

"Do we not need to cry halt? and to become more familiar with the reliable drugs already in use? The efficiency of any arm in service is very largely due to the skill with which it is used, and this can be acquired only by constant drill and exercise.

"I have said this because my report should properly consider materia medica as well as practice."

Succeeding this, Dr. Bailey spoke of the all-absorbing question of cholera. He expressed himself as skeptical concerning the "comma bacilli" theory of the origin of the disease, and while ready to accept any theory that admits of demonstration, he was yet inclined to think that in climatic and telluric conditions we must yet look for the most potent factors in the causation of the disease. His grounds for skepticism will, perhaps, be better understood from the following remarks, which occurred in his paper:

"We have no apprehension of cholera in winter time, no matter how many infected ships reach our shores. We find persons arguing that season has nothing to do with it; that cholera prevailed in Russia amid ice and snow, which may have been true, for they forget how that the peasants

of Russia live in adobe houses, kept up to a temperature that would satisfy the most cold-blooded. Why don't they cite cases in our own country, in our own experience, to substantiate the statement? The thorough conviction of the late Prof. Theo. S. Bell was that this disease was altogether due to telluric or climatic influences, and I am constrained to think that few men in the present age have given such undivided attention to the etiology of this infectious disease as he. I do not wish by this proposition to invalidate the claim of the germ theory of the disease, but to put it alongside of malarial fever, yellow fever, and the plague.

"Some other propositions dependent upon this one I would like to discuss if I had time, particularly the subject of quarantine as practiced in this country. Some curious things are done in this business, and apparently without the inconsistency striking the average mind at all. We establish a quarantine, no matter where, and place doctors and others in charge. Who protects the doctors and others that come in contact with those subjected to the quarantine? How would this practice, in stamping out variola, satisfy us? Establish a quarantine against the small-pox, and place in charge men who are not exempt by virtue either of having had the disease or having been vaccinated. What would you think of that, and yet in what is it different from this?"

"I do not insist that the cause of cholera is not portable, but I do not believe that the cause of cholera is propagated by contagion. I would insist upon the quarantine of infected vessels or cars to the destruction of the germ or specific cause, whatever it may be.

"I like best the methods practiced by Dr. Joseph Holt, of the New Orleans Board of Health.

"Improved sanitation should be the watch-cry against such epidemics.

"I have not the time to discuss the symptomatology or the management of the disease. The impress of the poison is chiefly, in my judgment, upon the nervous system, as it is in malignant intermittent fever and yellow fever. Absorption from the alimentary canal and excreta by the kidneys are suspended. Treatment is successful only when applied in the early stages. Mortality is not materially affected by any means in our power after the stage of collapse. Morphia and atropia, hypodermically, meet the indications best.

"My imperfect paper is intended to be suggestive and not exhaustive, and if your wisdom is stimulated to develop by discussion more important facts, I shall feel myself content.

"I have stated what were my preconceived opinions; that now I am inclined to the plausible germ theory, and stand ready to bow to the inexorable power of logical demonstration when it shall be made."

Discussing the paper, Dr. Dudley S. Reynolds said:

"Dr. Bailey might have found less difficulty in formulating his skepticism if he had made it plausible. The microbes which cause cholera never appear in the blood of the patient nor in any secretion. They operate entirely upon the lining of the intestinal canal. By destructive action upon the epithelium, abrasions follow which drain so much of the fluids from the body

as to rapidly deplete the patient, who presently reaches the stage of collapse, and dies without any evidence whatever of the introduction of any sort of matter into the system. On the contrary, it is what has been withdrawn from the system through the abrasions or excoriations of the walls of the intestinal tract, which robs the patient of the vital fluids. If Dr. Bailey would study the published reports of Dr. French, of Wilkes-Barre, Pa., and Dr. E. O. Shakespeare, of Philadelphia, he would find perfectly conclusive evidence that the typhoid fever, which has prevailed with such disastrous effects in the town of Plymouth, originated in the contamination of the water-supply, by the discharges from a patient having that disease.

"No person who has studied the literature of the several epidemics of cholera which are known to have prevailed in different parts of the world will undertake to deny the influences of accumulations of fluid in filthy gutters and cesspools upon the water-supply, and the influence of this, in turn, upon the spread of the cholera. There is no comparison, as Dr. Bailey states, between the manner in which small-pox and cholera enter the system. Quarantine in the presence of small-pox prevents its spread, by limiting both the amount of poison and the number of susceptible people. In the case of cholera, the resting-place for the microbe prior to its introduction into the drinking-water, or its lodgment in the dew upon such vegetables as may be eaten uncooked, limits the chance of contact of the microbe with the vegetables, or the introduction of it into the water, provided only the aid of thorough sanitary police be employed for the thorough destruction of these cesspools or resting-places. In this way climatic and telluric influences may alone serve to propagate an epidemic of cholera, the air being powerless to carry it from one person to another directly. It must be swallowed, and this is generally through contaminated water."

Dr. McCormack, of Bowling Green, said:

"I very cordially agree with much that Dr. Bailey says in regard to the influence and importance of climatic and telluric conditions in the production of cholera. It seems to me that, admitting all this, the history of cholera in every country where it has prevailed teaches that there must be something added besides these influences. In those seasons when it has prevailed in parts of this country, other portions having like climatic and telluric influences exercising their influence have, when this other particular influence which we recognize as the specific cause of the disease was inoperative, escaped. I may mention a case where a negro coming from Lebanon, where the disease was prevailing in 1873, to Columbia, where no cholera had previously existed, was suddenly seized on his arrival at the latter place so violently that he died of the disease in a closet attached to a livery stable. The Monday following this occurrence was county court day. Many farmers from the surrounding country while in the city had occasion to visit the foul closet in which the negro died. In forty-eight hours afterward the cholera was epidemic throughout the county, the primary cases occurring in those who had visited the city and been in this closet.

"During the same year the cholera was im-

ported from the railway station to Lebanon, and prevailed at first in the families of some negroes, who lived on the banks of a ravine, the cases being confined to them for some time. Out of the wells from which they gained their water supply, and which were situated but a very short distance from their houses, water was hauled to the fair grounds and put in barrels for the use of the people attending the fair, and in the next forty-eight hours cholera was epidemic throughout Marion county.

"In Genoa, last year, contrary to what occurred in Marseilles and Toulon, the cholera made its appearance in the best quarters of the city. This was an inexplicable mystery until it was determined that the water supply of the city is derived from three companies, two using a large stream, and one using the water of a smaller stream. This smaller stream supplied the affected portion of the city. It was then discovered that not far above the inlet of this water supply the cholera had been prevailing among the miners located there, the filth from whose settlement was discharged into the stream. So far as we were able to gather the evidence in this way, from city to city, it all points to the existence of a specific cause, capable of transmission thus from one point to another, and it would appear that we can no more have cholera without this specific seed than we could expect to raise a crop of oats or wheat or barley without scattering the seeds upon the ground prepared to produce it."

Dr. J. B. Marvin said:

"There are one or two points in Dr. Bailey's paper I wish to call attention to. We have more than one kind of comma bacillus. Dr. Koch has conclusively proved that the comma bacillus which he describes is characteristically distinct from those which some observers have claimed to be inert. Klein claimed there was nothing in the theory, and to show his faith, publicly drank water containing the comma bacilli. But Klein was forced to admit, in a discussion with Watson Cheyne, that he was ignorant of the variety described by Koch.

"Now, another point with reference to the activity of contagion. At certain places along the Ganges river religious customs call for the assemblage of large numbers of people to drink and bathe in the waters. This is done with impunity and without cholera occurring until some arrival from Bengal, where the disease prevails, carries the specific poison to its waters. This once done, thousands at once fall victims to the disease. At Mecca this experience is repeated almost every year among the hosts who gather there to drink of the holy well. When some pilgrim arrives from an infected district and the water once becomes contaminated by the poison he has carried, thousands at once fall a prey to this fell destroyer."

The hour of meeting being late, at the conclusion of these remarks the Society adjourned to meet in the evening, when papers were read by the President, Dr. Pinckney Thompson, of Henderson, and by Dr. Williams, of Cincinnati.

THURSDAY FORENOON.

After the transaction of miscellaneous business the session opened by Dr. J. M. Matthews, Com-

mittee on Surgery. The scope of the subject being so great, his remarks were confined to the operations of recent attempt. On the subject of anaesthetics he spoke of cocaine and its applications to general surgery. Admitting its value in eye, ear, and throat practice, he had yet found that where a large amount of skin has to be cut the local applications of rhigolene by spray are equal, if not superior to it. After speaking of general etherization, and condemning the practice of rectal anaesthesia, he spoke as follows upon "Antiseptic Surgery:"

ANTISEPTIC SURGERY.

"Upon no subject in surgery is there so wide a difference of opinion as that of antiseptics. The Listerian method has been handled 'without gloves,' and although the attacking party has succeeded in routing it from the hospitals, etc., they find dissension in their own ranks as to what to substitute. The most prominent antiseptics in use are, viz.: Bichloride of mercury, iodoform, hydrate of chloral, subnitrate of bismuth, turf-dressing, boracic acid, eucalyptus oil, aseptol, naphthalin, listerine, etc., etc. In hospital practice bichloride of mercury perhaps heads the list. It is employed in all the great operations. The strength of the solutions is anywhere from one part of the agent to 1,000 or 5,000 parts of water. The question to be determined is, in what dilution can bacteric life exist. Koch decides that the spores are destroyed in a solution of one to twenty thousand parts; while others contend that they have detected them in much stronger solutions.

"Iodoform finds its greatest advocate in Billroth. Indeed, the German surgeons seem agreed upon this agent as the antiseptic par excellence. The most important question in its use is, can it be absorbed in sufficient quantity to produce poisonous effects? Several years ago I detailed my experience with the use of the drug to this society. I then mentioned that I believed the fears of the profession in regard to its use were not well founded, reciting instances where I had used it in large quantities in the rectum in cases of ulceration, cancer, etc. The packing of large wounds, as after resection of joints, etc., may not be advisable, yet it is practiced by some surgeons, notably Billroth. All in all, it may be regarded as one of the best antiseptics.

"*Turf Dressing.*—There are a few advocates of turf as a surgical dressing. It is said that its discovery was accidental, yet its application would seem to be theoretically appropriate. Healing under a scab is regarded as one of the best modes in the healing of wounds, and it is upon this principle that many syphilitics resort to the mud bath of Hot Springs. Turf is both an absorbent and antiseptic. A preparation of mineral earth, to be used for this purpose, is put up by the Natural Pharmacy Association of Baltimore.

"*Naphthalin.*—It is claimed for this agent that the power in preventing decomposition of organic fluids is remarkable, and that the appearance of bacteria and micrococci can be prevented in pus by the addition of a small quantity of it.

"*Listerine.*—Among the very best and safe antiseptics is listerine. The more I use it the better I am pleased with it, especially so in large sup-

purating wounds. In such many of the other antiseptics are dangerous, but listerine is free from danger, and meets the indicated terms as well. It is a mild stimulant, a safe antiseptic, and free from any offensive odor. I will not take the time to discuss the other antiseptics."

He continued: "A question of great moment to the surgeon is, can he, while attending cases of pyemia, erysipelas, etc., by the use of disinfectants, prevent the contagion that is said to be communicable? Without stopping to discuss any theory in regard to contagion under these circumstances, I desire to quote the views of Prof. Volkmann, as expressed in a letter to Dr. George F. French, of Minneapolis. He says: 'A surgeon who disinfects himself well can, immediately after making a post-mortem, undertake any operation known to surgery.' This is a strong saying of the eminent German, and very hard to believe."

After addressing a few remarks upon abdominal surgery, he passed on to the

SURGERY OF THE KIDNEYS.

"Certain operations for the relief of kidney affections are now regarded as justifiable, and are attended with success, viz.: nephrotomy, nephrolithotomy, and nephrectomy. The greatest trouble in cases requiring such operations, as renal calculus, is to tell of a certainty that it exists. All the typical symptoms may exist without the presence of the stone. The diagnosis is the most difficult part. Nothing is definite except exploratory incisions. Under what conditions this procedure is warrantable must be decided by the surgeon. It is certain that by its detection and removal the most absolute and perfect relief is given.

"*Thoraco Plastic Operation of Estlander.*—One of the most interesting diseases falling under the surgeon's care is empyema, the relief of which—I refer to the chronic form of the disease—is so very unsatisfactory. An operation is proposed by Estlander for the eradication of the sequela of the disease, viz., the obliteration of the suppurating cavity and the occlusion of the pleura fistulae. It is the common custom with surgeons to treat empyema by the free incision and drainage and a free washing out of the cavity, together with disinfection.

"The results of such treatment are, in the main, satisfactory, in that fifty per cent. have recovered. But seventeen per cent. are followed by permanent fistulae. Estlander's operation is intended to overcome this latter percentage. The indication for the operation is when the fistula has existed several months and resisted ordinary treatment; the contra-indication is the existence of tuberculosis, albuminuria, or great emaciation. If the latter exist without the former, I do not know that it should stand in the way of an operation. Large fistulous tracks around the rectum have been freely laid open by me in the emaciated subject, and the stoppage of drainage was of material advantage to the patient. As many as six ribs have been removed during the operation, but it is usual to remove two or three only, and this is accomplished by one incision. The details of the operation are very simple. The most favorable position is upon the lateral portion of the thorax, in the axillary line, the intercostal

spaces being covered by the serrations of the *serratus magnus*. The length of the incision and portions of ribs removed depend upon the size of the cavity in the horizontal direction. The first and second and the eleventh and twelfth ribs are always left intact.

"For many statements contained in this paper I am indebted to the authors of the operations, who have been kind enough to answer questions and help me to arrive at satisfactory conclusions. In other instances the detailing of cases, by men who have performed the operations, has helped me materially. If nothing new has been added to our surgical knowledge by this report, I have succeeded at least in drawing your attention to those operations concerning which there has been much difference of opinion, and aided some little in their elucidation, I feel satisfied."

DISCUSSING THE PAPER.

Dr. M. F. Coomes, of Louisville, said:

"The most important point which now occurs to me is with reference to the speaker's words concerning abdominal surgery. It is a well known fact that the tissues of the abdomen, and particularly of the intestines, are abundantly supplied with blood; in this respect being similar to the tissues of the face, and they, therefore, when other circumstances are favorable, heal readily and completely. For my own part, if I were suffering from a wound of the abdominal structures, and any hesitancy should be manifested on the part of the surgeon called to my side about opening up the abdominal cavity in order to determine and, if possible, remedy the mischief done, I should unhesitatingly insist upon its being done at once.

"With regard to the use of iodoform, I would say that my experience with the drug has been somewhat peculiar. I have used it in two instances in the form of insufflation upon the throat. In each case, within a few minutes after the application, the patients began to grow dizzy, complaining of a feeling of weight in the epigastrium, the pulse being quickly increased in frequency. One of these parties was a physician, and he, of course, knew what the medicine was, and suspected the cause of these sensations. He assured me that he repeated the dose again and again, always with uniform results."

Dr. Williams, of Cincinnati, said:

"We have been in the habit of using cocaine a great deal in painful affections, in paracentesis of the drum membrane, etc., and with uniform satisfaction. We have sometimes used it in enucleation of the eyeball, and we have come to the conclusion that none of the American preparations are equal in efficiency to that made by Merck, of Darmstadt. There is no amount of experience in this world that has been entirely satisfactory to me in any department of work that I know of in this world, but at the same time there is no kind of doubt that the introduction of this local anæsthetic has proved a very valuable addition to the means we already possess for the relief of human suffering. It is not applicable to all operations, however.

"Dr. Sattler, who is associated with me, yesterday removed a tumor from the temple of a young woman, and he attempted to produce an-

esthesia by cocaine, using three or four injections into its structure. I don't know how much more she would have complained at the operation without the influence of the drug, but she certainly complained enough with it. In the extraction of cataract we use it now altogether, without resorting to general anesthesia.

"Dr. Vance said he had made frequent applications of it to reduce the pain of small operations, adding first applications of the drug as the operation progressed. In this way he had found it very satisfactory.

"Dr. Roberts said he had used it frequently in operating upon small tumors; in one case the operation was followed by the application of caustic and no pain was complained of. He had used it also in fissures, but without any good effects. In irritation or inflammation of the prostatic gland he had had some happy results.

"Dr. Scott said: "Several points in this paper struck me with much force, among others that a surgeon can pass from the post-mortem table to the side of a woman in ovariectomy with no danger of carrying infection to the woman being operated upon. How far would any of us feel justified in carrying practice like that? We all feel it improper to expose ourselves to any such disease as puerperal fever, traumatic fever, or erysipelas, while we are expecting to be called to a case of confinement, and I am led to ask how much can we measure our own personal responsibility, how far can we in justice expose ourselves to these diseases we regard as infectious and contagious before going to a case of confinement, and how far can we carry disinfection to render it safe after seeing such a case to attend one of confinement?"

Dr. Reamy, of Cincinnati, a well-recognized authority on obstetrics and gynecology, said: "The paper just read was extremely interesting and instructive to me. So far as the statement that it is entirely safe to pass from the dead-house to the operating-table is concerned, I can concede that, because it is a well-known fact that the germs of decomposition which play havoc in the dead-house are not the germs that threaten danger to the living. It is a question of greater importance to determine if it is not more dangerous to pass to the lying-in chamber from the house of the living. I have no hesitation, gentlemen, in saying that if a man is in constant attendance upon a case of erysipelas or traumatic or puerperal fever, unless he is in a position to be able to change his clothing, even to his shoes and socks, and be shampooed by his barber, and take a bath, he ought not to approach the lying-in chamber. But granting that a man can so disinfect himself, it is yet safe to say that a man who is in attendance morning, noon, and night upon these contagious diseases is not a suitable person to attend a case in obstetrics. But can a man subject himself to sufficient disinfection to justify him in attending a case of obstetrics after exposure in the sick-room of a patient suffering from puerperal fever? I believe he can. I was in consultation very recently at Glendale, O., in a case of puerperal septicæmia where at my last visit it was necessary for me to make complete examination and expose myself in this way to the utmost. The case proved fatal and the exposure was complete. On the next evening I was summoned to attend a case of confinement. As soon as I arrived home from the case of which I speak, my clothing was completely removed from head to foot; I took a bath, and followed it by another containing as much carbolic acid as I felt inclined to bear; went to my barber, and in the evening retired to the house of the case I speak of, where I remained almost constantly for the next twelve hours, and no bad results whatever attended the case. I certainly could not have felt justified in going without taking these precautions. It does not do in these cases to simply wash the hands with great care in solutions of carbolic acid and water."

Papers were then read by Drs. Vance and Mcmurtry, abstracts of which, with the discussion they elicited, will appear in a following report.

(To be continued.)

Purification of Drinking Water.

The average healthy adult man takes into his system four and a half pounds of water daily, and with it too often a dangerous quantity of foreign matter and disease-producing germs. In very many homes during the summer months, water that otherwise would nauseate the drinker, is made cold by ice, and then is hastily swallowed, the coldness masking its offensiveness. Unfortunately for the health of the consumer, the addition of ice does not render the impurities in water innocuous, but often adds to it its own contribution of disease-germs. The only safe-guard to the consumer is in giving his personal attention to the filtration of the water used in his household. Water slowly percolated through crushed vegetable charcoal will escape from it not only cleansed of particles held in suspension, but also of organic and other matter. The cheapness of charcoal is such that it is obtainable by all classes, and when soiled, a fresh quantity can be substituted at trifling cost. The most effective filtration is obtained by placing crushed charcoal in an earthen vessel, so arranged as to compel the slow passage of the water through it, as all efforts at rapid filtration have proven inefficient. Only wooden spigots should be used in drawing off the water. A reservoir for the filtered water, with a separate ice chamber, will permit the water to be sufficiently chilled and keep all ice impurities out. Such a contrivance requires but very little room, is easily cleaned, and renewed, and is efficient in freeing water from impurities.—*Dr. Edwin J. Hove, in American Agriculturist for July.*

Danger from Phthisical Farm Laborers.

The Paris correspondent of the *Brit. Med. Jour.* (May 16, 1885), writes: "A farm at Charenton has furnished somewhat startling evidence of the transmissibility of tuberculosis from man to domestic animals. One of the farm-servants, who was phthisical and too weak to undertake fatiguing duties, was placed in charge of the poultry yard. He grew steadily weaker, and coughed incessantly, expelling a quantity of sputa, which the fowls were observed to swallow with avidity. In a few weeks the fowls began to die off. The owner of the farm sent one of the fowls to the veterinary school at Alfort. M. Nocard found that the lungs and liver were infested with tubercles about the size of a pea, and of a greyish-yellow color. In

a microscopic preparation, there were numbers of bacilli. The fowls were killed, and the poultry yard disinfected. A less honest farmer might have sent the tuberculous fowls to market, a probability which doubtless has been, and will yet be, a certainty not always easy to discover. The danger attending the consumption of diseased poultry or milk from tuberculous cows, indicates that a rigorous system of inspection ought to be organized for markets, farms, and poultry yards."

Items.

—Dr. H. V. Sweringen has been appointed pension examining surgeon at Fort Wayne, Ind., and re-elected health officer of Allen county.

—The Spanish Congress for the discussion of Hydrology and Climatology, which was fixed for October 1, 1885, has been postponed to the same date next year.

—The King of Greece has recently conferred on Dr. Morris H. Henry, of New York, the Gold Cross, and created him an officer of the Royal Order of the Saviour. The honor was conferred for services rendered to medical science, on the recommendation of the Faculty of the University of Athens.

—A foreign exchange says that powdered rice as a styptic remedy has a great effect on fresh wounds, much superior to oxide of zinc. By mixing from four to eleven per cent. of it with lint, and using the lint thus treated as a compress, it is very effectual and more valuable than subnitrate of bismuth, salicylic acid, or carbolic acid.

—If a saturated solution of hydrochlorate of cocaine in strong nitric acid be applied to the skin, instead of the painful smarting of the acid alone, a slight pricking sensation is the only sensory effect produced. An eschar is formed, but takes a longer time to appear than if the nitric acid be used alone. These results have been obtained by Messrs. Randolph and Dixon.—*Pharmaceutical Journal*.

—M. and Madame Victor Saint-Paul have given 25,000 francs to the Académie de Médecine, to be awarded as a prize to any one who can discover a remedy, to be recognized by the Académie, as efficacious in diphtheria. Until the remedy is found, the interest paid on the money is to be awarded every two years to those whose works and researches on diphtheria are recognized by the Académie as the best. This prize is open to competitors of all nations.

—Prof. G. Sée has observed in a large number of young men violent palpitations of the heart, which made him fear that they would be unfit for military service. Experience showed him, however, that the palpitations were not increased by exertion, and that, on the contrary, they tended to disappear gradually as the men got stronger. In these cases the palpitations were accompanied by a loud systolic murmur, which could be heard at the apex, but not over the large vessels. The heart was enlarged, the pulse sometimes irregular. In some cases there was dyspnoea or frontal headache. As regards the treatment, regular exercise, without fatigue, is to be enjoined; iodide of potassium and convallaria majalis sometimes do good.

—A case of excessive dilatation of the stomach is mentioned in the *Vratch*, which occurred in the clinic of Prof. Koshlakov, of St. Petersburg. The patient was a peasant, aged forty, and had been ill for three years. It was found that six litres of water could be introduced into the stomach without occasioning the man any inconvenience. The same journal records the case, by L. Scheffer, of a peasant, aged forty-nine, with intestinal obstruction, who, after the stomach had been twice washed out, passed a stool containing ascarides. Two grains of santonin were then given, with jalap, and about twenty round worms, which had been the cause of the obstruction, were passed.

—The *Lancet* says that from information published by the Immigration Office, Sydney, New South Wales, it appears that in the cities and larger townships of the Colony there is no lack of competent medical men, but in the newer and more remote districts they are too often conspicuous by their absence, and it is by no means unusual for the inhabitants of such places to advertise their willingness to guarantee a certain amount of income to a resident doctor. An experienced medical man, willing to "rough it" for a few years, will attain a competency much more rapidly than in England, especially if devoted to his profession and skilled in the treatment of complicated cases. Medical specialists possess a wide field in Australia, where institutions for the treatment of eye and ear diseases, etc., are practically unknown.

—To the British Gynecological Society, Dr. Lamprey described a case of double monstrosity. The patient had miscarried at the third month. She was 22 years old, and had had one child previously, who was born healthy. When Dr. Lamprey came to examine the ovum, he found it to consist of a double monster. The lower halves of the two sterna, and the whole of the abdomens, were united so intimately that, had the children arrived at maturity, and lived, it would have been extremely difficult for one of them to walk forwards without the other walking backwards. Or, supposing they walked sideways, the pelvis of each would have had to rotate in great measure upon the lumbar, or lumbro-sacral vertebrae, much more than could be accomplished. Had these fetuses come to their full time, no doubt they would have caused a long, painful, and exhausting labor.

QUERIES AND REPLIES.

Please state in your valuable REPORTER the formula for glycerinum acidi carbolic, spoken of in June 20, MEDICAL AND SURGICAL REPORTER. S. N. ROWELL, M. D.

Ans.—Take of carbolic acid one ounce (avoirdupois), glycerine four fluid ounces (imperial measure), rub them together in a mortar until the acid is dissolved.

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MARRIAGE.

WARD—CARPENTER.—June 25, 1885, at Waverly, Pa., Dr. Stanley M. Ward and Carrie, only daughter of E. G. Carpenter, esq.